

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35501

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MYRA POWELL

2. Date of Death

Oct

Day 25 Year 2000

3. Time of Death

3:30 AM

4a. Facility Name (If not institution, give street and number)

Deers Head Center

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

Wicomico

Funeral
Director

5. Social Security Number

217-10-2467

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 13, 1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

812 College Lane Apts.

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
216a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Publishing Co.

17. Father's Name (First, Middle, Last)

Asher Baker

16. Mother's Name (First, Middle, Maiden Surname)

Roxie Wingate

19a. Informant's Name/Relationship (Type, Print)

Brenda C. Morris/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1102 Nevins Place, Salisbury, MD 21804

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Salisbury Crematory

Date

10/26/00

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

David A. Thompson

22. Name and Address of Facility

Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 2180423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cerebral Vascular Accident

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 mo

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Normal Pressure Hydrocephalus

Due to (or as a consequence of):

2+ mos

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE LUNG DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined26a. Date of Injury
(Month, Day Year)26b. Time of
Injury26c. Injury at
Work?1 ☐ Yes 2 ☐ No

26d. Describe how injury occurred

26e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)26f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Virginia A. Dulaney MD

29c. License number

D33905

29d. Date signed (Month, Day, Year)

10/25/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIRGINIA A Dulaney M.D. PO Box 2018 SALISBURY Md 21802

31. Date filed (Month, Day, Year)

OCT 26 2000

32. Registrar's Signature

Anne S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

00 35502

Reg. No.

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

00 35503

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Gordon M. Ragsdale				2. Date of Death Month Day Year October 23, 2000		3. Time of Death 12:35 AM	
4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery	
5. Social Security Number 224-60-0508		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 28, 1913	
9. Birthplace (State or Foreign Country) Indiana							
Usual Residence of Decedent							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 3701 International Drive #437				10f. Zip Code 20904		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Personnel Officer		16b. Kind of Business/Industry United States Government	
17. Father's Name (First, Middle, Last) Dacy W. Ragsdale				18. Mother's Name (First, Middle, Maiden Surname) Edna Davidson			
19a. Informant's Name/Relationship (Type, Print) Naomi D. Ragsdale/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 3701 International Drive #437, Silver Spring, Maryland			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		Date October 27, 2000		20c. Location - City or Town, State Bethesda, Maryland	
21. Signature of Funeral Service Licensee M00846				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIAC ARREST Due to (or as a consequence of): b. PNEUMONIA Due to (or as a consequence of): c. ATRIAL FIBRILLATION Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier ATTAN KASID, M.D., Ph.D.				29c. License number D55054		29d. Date signed (Month, Day, Year) OCTOBER 23, 2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ATTAN KASID, 17519 REDLAND ROAD, ROCKVILLE, MARYLAND							
31. Date filed (Month, Day, Year) OCT 25 2000				32. Registrar's Signature B. Sparks			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35504

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ryland Randolph, Jr.

2. Date of Death

Month Day Year
October 21, 2000

3. Time of Death

6:23 AM

4a. Facility Name (If not institution, give street and number)

1859 Featherwood St

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

227-84-7920

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan 3, 1956

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1859 Featherwood St

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
Black15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Child Psychologist

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Ryland Randolph, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Carl Price

19a. Informant's Name/Relationship (Type, Print)

Rylene Mickleberry/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

33 Buck Rd, Stafford, VA 22554

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Zion Baptist Church

Date

Oct 27

20c. Location - City or Town, State

Mechanicsville, VA

21. Signature of Funeral Service Licensee

▶ *Olanya J. Donnell*

22. Name and Address of Facility Hines-Rinaldi Funeral Home

11800 New Hampshire Ave, Silver Spring, MD 20904

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Acute Renal Failure

Due to (or as a consequence of):

HIV Nephropathy

Due to (or as a consequence of):

Pneumocystosis

Due to (or as a consequence of):

A.I.D.S.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Kaposi's Sarcoma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending
Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

▶ *William C. Sanchez*

29c. License number

D0020089

29d. Date signed (Month, Day, Year)

October 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William C. Sanchez 2232 Q St, NW, Washington, DC 20008

31. Date filed (Month, Day, Year)

OCT 25 2000

32. Registrar's Signature

▶ *Anna B. Sparks*State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35505

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOROTHY REBHAN				2. Date of Death Month Day Year OCTOBER 22, 2000				3. Time of Death 11:10 AM	
	4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL				4b. City, Town, or Location of Death BETHESDA				4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 293-09-4554		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) OCT 01, 1918		9. Birthplace (State or Foreign Country) POLAND							
Usual Residence of Decedent										
10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 5901 MONTROSE ROAD #S500				10f. Zip Code 20852				10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry OWN HOME		
17. Father's Name (First, Middle, Last) SAMUEL DISHMAN				18. Mother's Name (First, Middle, Maiden Surname) ANNA OKUNIEWICZ						
19a. Informant's Name/Relationship (Type, Print) HERMAN REBHAN/HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5901 MONTROSE ROAD #S500, ROCKVILLE, MD 20852						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID MEMORIAL GDNS				Date OCTOBER		20c. Location - City or Town, State FALLS CHURCH, VIRGINIA
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. <u>ATHEROSCLEROTIC VASCULAR DISEASE plus</u> Due to (or as a consequence of): b. <u>Hyperosmolar Coma</u> Due to (or as a consequence of): c. <u>Diabetes Mellitus</u> Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 3 days 3 days 3+ years										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>GASTRIC CARCINOMA</u> <u>ACUTE RENAL FAILURE</u> <u>UROSEPSIS</u>										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 29c. License number D32610 29d. Date signed (Month, Day, Year) 10-22-00										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T.J. NAMARA, 10215 Fernwood Rd, Bethesda, Maryland 20817										
31. Date filed (Month, Day, Year) OCT 24 2000 32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

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Examiner

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State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

00 35506

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Linda McCormack Rebman				2. Date of Death Month Day Year October 18 2000		3. Time of Death 1225 AM						
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY						
Funeral Director	5. Social Security Number 578-56-2647	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jun 25, 1941		9. Birthplace (State or Foreign Country) DC					
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State MD		10b. County Montgomery		10c. City, Town or Location Potomac		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	10e. Street and Number 12112 Gatewater Dr.				10f. Zip Code 20854		10g. Citizen of What Country? United States						
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home								
	17. Father's Name (First, Middle, Last) Donald Adair McCormack				18. Mother's Name (First, Middle, Maiden Surname) Thelma Virginia Money								
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Donald McCormack / Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Meadow La., Vienna, VA 22180								
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date Oct 20 2000		20c. Location - City or Town, State Beltsville, MD						
	21. Signature of Funeral Service Licensee Beverly L. Helotte		22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Avenue Silver Spring, MD										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Hypoxic encephalopathy</td> <td rowspan="4">Approximate interval Between Onset and Death</td> </tr> <tr> <td>b. Cardiac arrest</td> </tr> <tr> <td>c. Ischemic cardiomyopathy</td> </tr> <tr> <td>d.</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Hypoxic encephalopathy	Approximate interval Between Onset and Death	b. Cardiac arrest	c. Ischemic cardiomyopathy
Immediate Cause (Final disease or condition resulting in death)	a. Hypoxic encephalopathy	Approximate interval Between Onset and Death											
	b. Cardiac arrest												
	c. Ischemic cardiomyopathy												
	d.												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier Alan S. Chavaler MD				29c. License number 29453		29d. Date signed (Month, Day, Year) October 18, 2000							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALAN S CHAVALER 15115 SHADY GROVE RD ROCKVILLE MD 20850													
31. Date filed (Month, Day, Year) OCT 23 2000		32. Registrar's Signature B. Sparks											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35507

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES E. RIGGS, SR.				2. Date of Death Month Day Year OCT. 18, 2000		3. Time of Death 4:28 AM	
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 217-14-7974		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 4, 1921	
	9. Birthplace (State or Foreign Country) Maryland		10e. State MD		10b. County Montgomery		10c. City, Town or Location Gaithersburg	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 17032 Downing Street		10f. Zip Code 20877		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 42-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 1 yr		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bldg. Service Worker		16b. Kind of Business/Industry Montg. Co. Schools			
	17. Father's Name (First, Middle, Last) Bradley W. Riggs				18. Mother's Name (First, Middle, Maiden Surname) Alta L. Thomas			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Betty J. Riggs (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17032 Downing St., Gaithersburg, MD 20877			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD. Veterans Cem.		20c. Location - City or Town, State 10/25/00 Crownsville, MD		21. Signature of Funeral Service Licensee <i>George R. Snowden</i>	
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. CORONARY ARTERY DISEASE Due to (or as a consequence of):			
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>D. M. Hannon</i>			
	29c. License number D2312H				29d. Date signed (Month, Day, Year) OCTOBER 18, 2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DENNIS M. HANNON, MD 1346 PILLARD DRIVE ROCKVILLE, MARYLAND 20850				31. Date filed (Month, Day, Year) OCT 24 2000			
	32. Registrar's Signature <i>B. Sparks</i>				33. Date of Death (Month, Day, Year) OCT. 18, 2000			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35508

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Milton Ritter				2. Date of Death Month Day Year October 21, 2000		3. Time of Death 1:00 am		
	4a. Facility Name (If not institution, give street and number) Holy Cross Rehabilitation and Nursing Center				4b. City, Town, or Location of Death Burtonsville		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 103-03-2515	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 8, 1920		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 1307 Mullins Street				10f. Zip Code 20904		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Physicist		16b. Kind of Business/Industry Aerospace/ NASA				
	17. Father's Name (First, Middle, Last) Bernard Ritter				18. Mother's Name (First, Middle, Maiden Surname) Regina Meltzer				
	19a. Informant's Name/Relationship (Type, Print) Edith E. Ritter/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1307 Mullins Street, Silver Spring, MD 20904				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 10/22/00		20c. Location - City or Town, State Alexandria, VA		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. Metastatic Colon Cancer Due to (or as a consequence of):								1 year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Enterocolitis						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number D 08944		29d. Date signed (Month, Day, Year) October 21, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin C. Shargel, MD 3720 Farragut Ave., Kensington, MD 20895-2110									
State Registrar	31. Date filed (Month, Day, Year) OCT 23 2000		32. Registrar's Signature 						

ORIGINAL

00 35509

Reg. No.

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35510

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THEODORE ROSENBERG				2. Date of Death Month Day Year OCT. 24, 2000		3. Time of Death 1:51 PM	
	4a. Facility Name (If not Institution, give street and number) SUBURBAN HOSPITAL				4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 578-38-4049		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) 8/15/12	
	9. Birthplace (State or Foreign Country) NH		10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location BETHESDA	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 9507 PAGE AVE.		10f. Zip Code 20814		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DEPT. OF DEFENSE		16b. Kind of Business/Industry US GOVERNMENT				
17. Father's Name (First, Middle, Last) MORRIS ROSENBERG				18. Mother's Name (First, Middle, Maiden Surname) BENA NEEDLE				
19a. Informant's Name/Relationship (Type, Print) LESLIE R. WOLFE / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5324 BALTIMORE AVE., CHEVY CHASE, MD 20815				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID MEM. GARDENS		Date 10/26		20c. Location - City or Town, State FALLS CHURCH, VA		
21. Signature of Funeral Service Licensee  DANIEL SIMONS		22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): b. MYOCARDIAL INFARCTION Due to (or as a consequence of): c. ARTERIOSCLEROSIS Due to (or as a consequence of): d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number H37188		29d. Date signed (Month, Day, Year) 10/25/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM SWANN, MD, 8600 OLD GEORGETOWN RD., BETHESDA, MD 20817								
31. Date filed (Month, Day, Year) OCT 26 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

00 35511

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35512

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Lee Ross				2. Date of Death Month Day Year October 12, 2000				3. Time of Death 11:00p.m.	
	4e. Facility Name (If not institution, give street and number) 232 Duke of Kent Street				4b. City, Town, or Location of Death Chestertown				4c. County of Death Queen Anne's	
Funeral Director	5. Social Security Number 524-20-7427		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) April 27, 1920	
	9. Birthplace (State or Foreign Country) Lead, South Dakota		10a. State Maryland		10b. County Queen Anne's		10c. City, Town or Location Chestertown		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Usual Residence of Decedent		10e. Street and Number 232 Duke of Kent Street		10f. Zip Code 21620		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Metallurgist		16b. Kind of Business/Industry Research						
17. Father's Name (First, Middle, Last) Kirb Elmer Ross				18. Mother's Name (First, Middle, Maiden Surname) Marie Margaret Cook						
19a. Informant's Name/Relationship (Type, Print) Jane Hudson Ross				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 232 Duke of Kent Street, Chestertown, Maryland 21620						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation Center, LLC 10/13/2000		20c. Location - City or Town, State Stevensville, Maryland						
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>RESPIRATORY FAILURE</u> Due to (or as a consequence of): b. <u>CHRONIC OBSTRUCTIVE PULMONARY DZ</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <u>DEMENTIA</u>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number D35048		29d. Date signed (Month, Day, Year) 10/13/2002		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric F. Ciganek 2540 Centreville Road, Centreville, Maryland 21617				31. Date filed (Month, Day, Year) OCT 16 2000		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1000 1 1 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35513

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Henry George Reintzell, Sr.				2. Date of Death Month October Day 23 , Year 2000		3. Time of Death 17:30		
	4a. Facility Name (If not institution, give street and number) 40240 Busy Corner Road				4b. City, Town, or Location of Death Loveville		4c. County of Death St. Mary's		
Funeral Director	5. Social Security Number 213-40-9855		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) September 28, 1943		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Loveville		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 40240 Busy Corner Road		10f. Zip Code 20656		10g. Citizen of What Country? U S A	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction		16b. Kind of Business/Industry Self Employed		17. Father's Name (First, Middle, Last) James Columbus Reintzell		18. Mother's Name (First, Middle, Maiden Surname) Mary Bridgett	
19a. Informant's Name/Relationship (Type, Print) Theresa D. Reintzell (Spouse)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 105, Loveville, Maryland 20656		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Memorial Gardens		20c. Location - City or Town, State 10/26/2000 Leonardtown, Maryland	
21. Signature of Funeral Service Licensee <i>Michael J. Gardiner</i>		22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. NON-HODGKIN'S LYMPHOMA Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		Approximate Interval Between Onset and Death 10 MONTHS	
23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARCINOMA OF LUNG		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Cannot be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Robert J. Bauer, MD</i>		29c. License number D001416K		29d. Date signed (Month, Day, Year) 10-24-00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert J. Bauer, MD Mechanicsville, MD 20659		31. Date filed (Month, Day, Year) OCT 27 2000		32. Registrar's Signature <i>Bevera B. Sparks</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35514

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jane Elizabeth Raynor				2. Date of Death Month Day Year October 19, 2000		3. Time of Death 5:45 P.M.	
	4a. Facility Name (If not institution, give street and number) 22508 Iverson Drive				4b. City, Town, or Location of Death Great Mills		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 191-34-5311	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 57 Yrs.	8. Date of Birth (Month, Day, Year) November 23, 1942	9. Birthplace (State or Foreign Country) Pennsylvania			
	Usual Residence of Decedent							
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Great Mills		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 22508 Iverson Drive #601				10f. Zip Code 20634		10g. Citizen of What Country? U S A		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 Years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Licensed Practical Nurse		16b. Kind of Business/Industry Doctor's Office		
17. Father's Name (First, Middle, Last) John C. Brady				18. Mother's Name (First, Middle, Maiden Surname) Jane Ellif				
19a. Informant's Name/Relationship (Type, Print) John W. Raynor (Spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21983 Willis Drive, California, Maryland 20619				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Augustine Cemetery		20c. Location - City or Town, State King of Prussia, Pennsylvania		20d. Date 10/25/00		
21. Signature of Funeral Service Licensee Michael Gardiner				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650				
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Occlusive Pulmonary Thromboemboli Due to (or as a consequence of): b. Deep Vein Thrombosis of lower Due to (or as a consequence of): c. Extremities in Association with Due to (or as a consequence of): d. Osteomyelitis of Lumbar Spine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Joseph Pestaner, M.D.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) October 20, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) OCT 23 2000				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

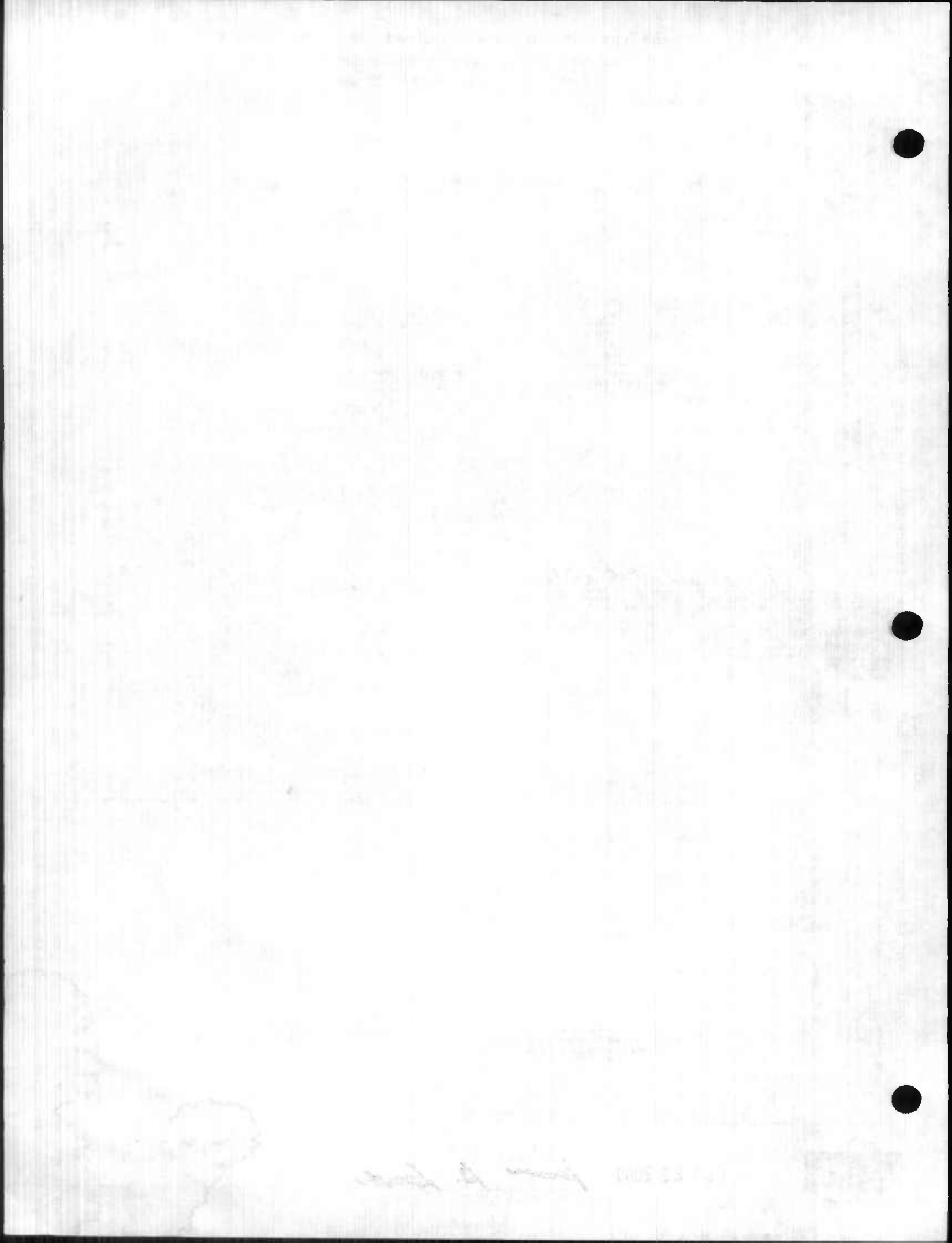
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35515

AMENDED #8,10e,10-13-00,DAN, ST. MARYS CO. Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Theodore Marshall Russell				2. Date of Death Month Day Year OCTOBER 5 2000		3. Time of Death 9:50 AM	
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital				4b. City, Town, or Location of Death Leonardtwn		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 212-24-4561		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 19, 1926	
	Usual Residence of Decedent Maryland		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Lexington Park	
To Be Completed by Funeral Director	10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 19170-Teddy-Way		10f. Zip Code 20653		10g. Citizen of What Country? United States	
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician		16b. Kind of Business/Industry US Government			
	17. Father's Name (First, Middle, Last) George Clayton Russell				18. Mother's Name (First, Middle, Maiden Surname) Rose Alice Suite			
	19a. Informant's Name/Relationship (Type, Print) Linda S. Jones / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23444 Town Creek Drive, Lexington Park, MD 20653			
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Memorial Gardens		20c. Location - City or Town, State 10-10-00 Great Mills, MD			
	21. Signature of Funeral Service Licensee Mary B. Rizzo		22. Name and Address of Facility Brinsfield Funeral Home, P.A.		22. Name and Address of Facility 22955 Hollywood Road, Leonardtown, MD 20650-0279			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death): Sepsis. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: Myocardial infarction, Diabetes, Cholecystitis.							
	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
	24a. Was an autopsy performed? 1 Yes 2 No							
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ESRD CAD								
25. Was case referred to medical examiner? 1 Yes 2 No								
26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined								
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier R. Gill MD								
29c. License number 056096								
29d. Date signed (Month, Day, Year) 10/6/00								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJBINDER S. GILL M.D. PHILIP J. BEAN MEDICAL CENTER HOLLYWOOD, MD. 20636								
31. Date filed (Month, Day, Year) OCT 10 2000								
32. Registrar's Signature B. Sparks								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35516

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred Cameron Reeves				2. Date of Death Month Day Year October 4, 2000				3. Time of Death 10:25 a.m.		
	4a. Facility Name (If not institution, give street and number) 21540 White's Neck Road				4b. City, Town, or Location of Death Bushwood				4c. County of Death St. Mary's		
Funeral Director	5. Social Security Number 213-38-2592		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 28, 1908		9. Birthplace (State or Foreign Country) Maryland		
	10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Bushwood		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number 21540 White's Neck Road		10f. Zip Code 20618		10g. Citizen of What Country? United States							
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Schoolteacher		16b. Kind of Business/Industry Public Schools							
17. Father's Name (First, Middle, Last) Charles Benjamin Cameron				18. Mother's Name (First, Middle, Maiden Surname) Mary Isabel Vessey							
19a. Informant's Name/Relationship (Type, Print) Mary R. Wood / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11440 Plantation Drive, Charlotte Hall, MD 20622							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) All Saints Cemetery		20c. Date 10-9-00		20d. Location - City or Town, State Avenue, Maryland					
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279									
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive heart failure Due to (or as a consequence of): b. Cerebral hemorrhage Due to (or as a consequence of): c. Atrial fibrillation Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 2 wks 1 yr. 4 y 3			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number 00000506		29d. Date signed (Month/Day, Year) 10/9/00					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leon W. Berube, M.D., 28170 Old Village Road, Mechanicsville, MD 20659											
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-386-6000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35517

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Paula Renee Ridgell			2. Date of Death Month Day Year SEPT. 30, 2000		3. Time of Death 2345 PM	
	4a. Facility Name (If not institution, give street and number) ROUTE#5- 1 MILE SOUTH OF #245 INTERSECTION			4b. City, Town, or Location of Death LEONARDTOWN		4c. County of Death ST. MARY'S	
Funeral Director	5. Social Security Number 216-17-6818	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 18 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 19, 1982	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Lexington Park		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 18367 Chestnut Street			10f. Zip Code 20653		10g. Citizen of What Country? United States		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Clerk		16b. Kind of Business/Industry Title Company		
17. Father's Name (First, Middle, Last) Joseph Michael Ridgell				18. Mother's Name (First, Middle, Maiden Surname) Karen Denise Thompson			
19a. Informant's Name/Relationship (Type, Print) Joseph Michael Ridgell / Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18367 Chestnut Street, Lexington Park, MD 20653			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Michael's Cemetery		20c. Location - City or Town, State 10-4-00 Ridge, Maryland			
21. Signature of Funeral Service Licensee <i>Edward N. Brinsfield, Jr.</i>		22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Multiple Injuries</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 9/30/00		28b. Time of Injury 2340 HR		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) roadway		28d. Describe how injury occurred Subject driver of vehicle involved in multi-vehicle accident Route 5 near Smith 245 St. Mary's County Maryland			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Theodore M. King</i>		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) OCT. 1, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>THEODORE M. KING</i> 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) OCT 3 2000		32. Registrar's Signature <i>B. Sparks</i>					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35518

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Andrew Richards				2. Date of Death Month October Day 19th Year 2000				3. Time of Death 9:20 AM	
	4a. Facility Name (If not institution, give street and number) University of Maryland				4b. City, Town, or Location of Death Baltimore				4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number 506-64-1504		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) JULY 30, 1950	
	9. Birthplace (State or Foreign Country) NEBRASKA		10a. State MARYLAND		10b. County WICOMICO		10c. City, Town or Location SALISBURY		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 207 CRAFT ST				10f. Zip Code 21804				10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: ARMY		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MACHINIST				16b. Kind of Business/Industry GAS PUMP MANUFACTURER	
	17. Father's Name (First, Middle, Last) CECIL OMAR RICHARDS				18. Mother's Name (First, Middle, Maiden Surname) MARY GERTRUDE ZIEGLER					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) TERESA RICHARDS - WIFE				19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 207 CRAFT ST. SALISBURY, MD 21804					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) SPRINGHILL MEMORY GARDENS				20c. Location - City or Town, State 10/23/00 HEBRON, MARYLAND	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumothorax Due to (or as a consequence of): b. Right Cavitary Lung Lesion Due to (or as a consequence of): c. Immunosuppression Due to (or as a consequence of): d. Bone Marrow Transplant Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Non Hodgkins Lymphoma								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <td colspan="2">29c. License number P12417</td>				29c. License number P12417	
	29d. Date signed (Month, Day, Year) October 19, 2000									
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jean R Hou 42 South Greene Street Baltimore, MD 21236									
	31. Date filed (Month, Day, Year) OCT 23 2000				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35519

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edna Abia Sape					2. Date of Death Month Day Year OCTOBER 23 2000			3. Time of Death 1:45pm			
	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER					4b. City, Town, or Location of Death TOWSON			4c. County of Death BALTIMORE			
Funeral Director	5. Social Security Number N/A		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) July 10, 1934		9. Birthplace (State or Foreign Country) Ghana			
	Usual Residence of Decedent					10c. City, Town or Location Accra		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
10a. State Ghana		10b. County N/A		10e. Street and Number First Forest Avenue		10f. Zip Code N/A		10g. Citizen of What Country? Ghana				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher			16b. Kind of Business/Industry Education					
17. Father's Name (First, Middle, Last) Julius K. Mensah					18. Mother's Name (First, Middle, Maiden Surname) Christiana Tay							
19a. Informant's Name/Relationship (Type, Print) Kwaku M. Sape Husband					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) First Forest Avenue, Accra, Ghana							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) Osu Cemetery		20c. Date 11/12/00		20d. Location - City or Town, State Accra, Ghana			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Avenue, N.W., Washington, D.C. 20012							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. CEREBRAL HEMORRHAGE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last												
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown												
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SHOCK												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined					28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29b. Signature and title of certifier George A. Bedon MD		29c. License number D12732		29d. Date signed (Month, Day, Year) 10/24/2000			
30. Name and address of person who completed cause of death (item 23a) (Type, Print) GEORGE A. BEDON MD 6701 N. CHARLES ST. BALTIMORE MD 21204												
31. Date filed (Month, Day, Year) OCT 27 2000					32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35520

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Lutz Scheidt				2. Date of Death Month Day Year October 26, 2000		3. Time of Death 1:10 PM	
	4a. Facility Name (If not institution, give street and number) Wilson Health Care Center				4b. City, Town, or Location of Death Gaithersburg		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-32-0335	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 98 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 23, 1901		9. Birthplace (State or Foreign Country) Hungary
	Usual Residence of Decedent							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 301 Russell Avenue				10f. Zip Code 20877		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Collega (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT usa retired) Food Handler		16b. Kind of Business/Industry Food Service		
17. Father's Name (First, Middle, Last) Stephen Sarenchesh				18. Mother's Name (First, Middle, Maiden Surname) Rosa Unknown				
19a. Informant's Name/Relationship (Type, Print) Ann S. Lehman/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22820 Shiloh Church Rd., Boyds, Maryland 20841				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 10/27/00 Alexandria, VA.				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Gangrene Left Foot Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death days week
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D 33357		29d. Date signed (Month, Day, Year) October 27, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lee Jonathan Musher, M.D., 5530 Wisconsin Ave., Chevy Chase, Maryland 20815								
31. Date filed (Month, Day, Year) OCT 27 2000		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35521

Amend #1&30, 10/25/2000, BMW, Montg. Co.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) F. Frederick William Scott				2. Date of Death Month Day Year October 23, 2000		3. Time of Death 10:20 am	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 215-44-3533	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Apr 4, 1920		9. Birthplace (State or Foreign Country) Minnesota
	Usual Residence of Decedent							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Wheaton		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 2605 Parker Avenue				10f. Zip Code 20902		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanical Engineer		16b. Kind of Business/Industry US Navy		
17. Father's Name (First, Middle, Last) Frederick Hughes Scott				18. Mother's Name (First, Middle, Maiden Surname) Eleanor Love				
19a. Informant's Name/Relationship (Type, Print) Clara Scott / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2605 Parker Avenue, Wheaton, MD 20902				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 10/24/00		20c. Location - City or Town, State Alexandria, VA		
21. Signature of Funeral Service Licensee ► <i>Steven D Stroud</i>				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gastric Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death less than 5 months
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier ► <i>Rahul Giotra</i>				29c. License number D 32417		29d. Date signed (Month, Day, Year) October 23, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rahul Giotra, MD 12016 Georgia Ave., Wheaton, MD 20902								
31. Date filed (Month, Day, Year) OCT 24 2000		32. Registrar's Signature ► <i>B. Sparks</i>						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35522

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LOUISE P. SHIFRIN

2. Date of Death

Month Day Year
OCT. 24, 2000

3. Time of Death

17:24

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

120-32-4368

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

7/9/16

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

POTOMAC

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10718 POTOMAC TENNIS LANE

10f. Zip Code

20854

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

LOUIS PADOW

18. Mother's Name (First, Middle, Maiden Surname)

MOLLIE (UNOBTAINABLE)

19a. Informant's Name/Relationship (Type, Print)

RONALD SHIFRIN / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

756 COLLEGE PKWY., ROCKVILLE, MD 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MOUNT HOPE CEMETERY

Date

10/26

20c. Location - City or Town, State

WESTCHESTER CO., NY

21. Signature of Funeral Service Licensee

DANIEL SIMONS

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

IMMEDIATE

Due to (or as a consequence of):

b. DIABETES MELLITUS

30 YEARS

Due to (or as a consequence of):

c. ALZHEIMERS DISEASE

3 YEARS

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

12890DC

29d. Date signed (Month, Day, Year)

10/25/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JON M. WISEMAN, MD, 5410 CONNECTICUT AVE., NW, WASHINGTON, DC 20015

31. Date filed (Month, Day, Year)

OCT 26 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35523

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Henry S. Snyder				2. Date of Death Month Day Year October 25, 2000		3. Time of Death 1:15am	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579-42-9702	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 8, 1909		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1801 East Jefferson Street #627				10f. Zip Code 20852		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lawyer			16b. Kind of Business/Industry Private Practice	
17. Father's Name (First, Middle, Last) Joseph Snyder				18. Mother's Name (First, Middle, Maiden Surname) Bessie Semker				
19a. Informant's Name/Relationship (Type, Print) Allen R. Snyder / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7616 Arrowood Road, Bethesda, Maryland 20817				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Beth Shalom Cemetery		Date 10/27/00		20c. Location - City or Town, State Capitol Heights, MD
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Danzansky Goldberg Memorial Chapels, Inc 1170 Rockville Pike, Rockville, MD 20852				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION Due to (or as a consequence of): b. ATHEROSCLEROSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 1 day years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 8+1				29c. License number D26449		29d. Date signed (Month, Day, Year) 10/25/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARRY S. TALESNICK, MD 5454 WISCONSIN AVE CHEVY CHASE MARYLAND 20815								
31. Date filed (Month, Day, Year) OCT 27 2000				32. Registrar's Signature 				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35524

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Roy G. Stratton

2. Date of Death

Month Day Year
October 20, 2000

3. Time of Death

3:19 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

190-30-5680

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov 2, 1936

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8422 10th Avenue

10f. Zip Code

20903

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No 1960-
If Yes, Give
Year or Dates: 196513. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Customer Service Rep

16b. Kind of Business/Industry

United Parcel
Service

17. Father's Name (First, Middle, Last)

Calvin Stratton

18. Mother's Name (First, Middle, Maiden Surname)

Mary Lyons

19a. Informant's Name/Relationship (Type, Print)

Bertha A. Stratton/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8422 10th Avenue, Silver Spring, MD 20903

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

10/25/00

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

J. Keir Skiles

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W. Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. SEPSIS
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

days

b. HEPATIC FAILURE
Due to (or as a consequence of):

months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastc. Chronic Liver disease
Due to (or as a consequence of):

years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Syncope

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

J. Keir Skiles - MD

29c. License number

J 53411

29d. Date signed (Month, Day, Year)

October 21st 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JC Atesadri 3060 mitchellville Rd # 103 Bowie MD 20716

State
Registrar

31. Date filed (Month, Day, Year)

OCT 23 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

151-1-1

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JASON W. STRUCK				2. Date of Death Month OCTOBER Day 22 Year 2000		3. Time of Death 03:30 A.M.		
	4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL CENTER				4b. City, Town, or Location of Death CLINTON		4c. County of Death PRINCE GEORGE'S		
Funeral Director	5. Social Security Number 466-55-3935		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 20 Yrs.		8. Date of Birth (Month, Day, Year) DEC. 20, 1979		
	9. Birthplace (State or Foreign Country) TEXAS		10a. State MD.		10b. County PRINCE GEORGES		10c. City, Town or Location ANDREWS A.F.B.		
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1600 CALIFORNIA AVE.		10f. Zip Code 20762		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1998-2000		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: *		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HEAVY EQUIPMENT OPERATOR		16b. Kind of Business/Industry U.S. AIRFORCE					
17. Father's Name (First, Middle, Last) THOMAS STRUCK				18. Mother's Name (First, Middle, Maiden Surname) MARLA ENGLISH					
19a. Informant's Name/Relationship (Type, Print) THOMAS STRUCK/FATHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9835 BREARLY LOOP, FT. DRUM, NEW YORK 13602					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY		20c. Location - City or Town, State 10/26/00 RIVERDALE, MD.					
21. Signature of Funeral Service Licensee W.W. Chambers				22. Name and Address of Facility CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737					
23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injury Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last {								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 10/22/00		28b. Time of Injury 0239 AM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		28d. Describe how injury occurred Subject driving vehicle which was struck by vehicle		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) roadway		28f. Location (Street and Number or Rural Route Number, City or Town, State) Route 3014 Acton Lane, Wilder, Maryland			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Therese M. King				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) OCTOBER 23, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Therese M. King 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) OCT 26 2000		32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

100-3-300

100-3-300

100-3-300

100-3-300

100-3-300

100-3-300

100-3-300

100-3-300

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35526

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HENRY NICHOLAS STINE, JR.				2. Date of Death Month Day Year October 25 2000				3. Time of Death 5:25P.M.	
	4a. Facility Name (If not institution, give street and number) Civista Medical Center				4b. City, Town, or Location of Death LaPlata				4c. County of Death Charles	
Funeral Director	5. Social Security Number 222-20-1119		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) May 12, 1933		9. Birthplace (State or Foreign Country) Maryland	
	10a. State MD				10b. County Charles		10c. City, Town or Location Cobb Island		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 13239 Main Ave.				10f. Zip Code 20625				10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Brick Layer / Self-Employed Waterman				16b. Kind of Business/Industry Construction / Water		
17. Father's Name (First, Middle, Last) Henry Nicholas Stine				18. Mother's Name (First, Middle, Maiden Surname) Laura Annie Norris Stine						
19a. Informant's Name/Relationship (Type, Print) Lillian Stine/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 97 Cobb Island, MD 20625						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Ghost Cemetery				20c. Location - City or Town, State 10/30/00 Issue, Maryland		
21. Signature of Funeral Service Licensee David C. Epp 100945				22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. P.O. BOX 567 LA PLATA, MD. 20646						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Heart Failure Due to (or as a consequence of): Coronary atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Type 2 Diabetes Mellitus Chronic Obstructive Pulmonary Disease				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Henry L. Burke, M.D.				29c. License number D-0001009		29d. Date signed (Month, Day, Year) 10-25-00
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Henry L. Burke, M.D.				31. Date filed (Month, Day, Year) OCT 27 2000				32. Registrar's Signature James B. Smith		

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Handwritten text at the bottom of the page, possibly a signature or date.

JOHN WINSTON STEM, Sr.

State of Maryland / Department of Health and Mental Hygiene

JWV amend #23a, 27, 28a, b, c, d, e, f, G-789 11-13-00 dh Certificate of Death

Reg. No.

00 35527

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN WINSTON STEM, SR.				2. Date of Death Month Day Year OCTOBER 19, 2000		3. Time of Death 8:22 P.M.	
	4a. Facility Name (If not Institution, give street and number) 1440 HOODS MILL ROAD				4b. City, Town, or Location of Death WOODBINE		4c. County of Death CARROLL	
Funeral Director	5. Social Security Number 214-54-8090		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) Oct 10, 1949	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Carroll		10c. City, Town or Location Woodbine	
Usual Residence of Decedent								
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
10e. Street and Number 1440 Hoods Mill Road				10f. Zip Code 21797		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Police Officer			16b. Kind of Business/Industry Law Enforcement		
17. Father's Name (First, Middle, Last) James Everett Stem				18. Mother's Name (First, Middle, Maiden Surname) Virginia Bullock				
19a. Informant's Name/Relationship (Type, Print) Mrs. Sandra L. Stem (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1440 Hoods Mill Road Woodbine, MD 21797				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Park		20c. Location - City or Town, State Timonium, MD		20d. Date 10/23/00	
21. Signature of Funeral Service Licensee Brian L. Haight				22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. GUNSHOT WOUND TO BACK WITH PARAPLEGIA AND NEUROGENIC BLADDER COMPLICATED BY METASTATIC SQUAMOUS CELL CARCINOMA OF BLADDER								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE								
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) 7-6-1977		28b. Time of Injury 12:10 p.m.		28c. Injury at Work? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred POLICE OFFICER SHOT BY ANOTHER PERSON			28e. Place of Injury - At home, farm, street, factory, office, building, etc. (Specify) USE LOCATED AT					
28f. Location (Street and Number or Rural Route Number, City or Town, State) 2429 Brunswick Rd., BALTO CO MD								
29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Joseph Pestaner M.D.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) OCTOBER 20, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) OCT 24 2000			32. Registrar's Signature Geneva S Sparks					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #23A PER PHY G789 11-8-00 WR
Amend #19a, niece, 10/25/00, drw

State of Maryland / Department of Health and Mental Hygiene

00 35528

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VIRGINIA SOMERVELL			2. Date of Death Month Day Year OCTOBER 11, 2000			3. Time of Death 2:40 PM				
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital			4b. City, Town, or Location of Death Prince Frederick			4c. County of Death Calvert				
Funeral Director	5. Social Security Number 213 14 8398		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 9, 1905		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland			10b. County Calvert			10c. City, Town or Location Prince Frederick			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 610 Main Street					10f. Zip Code 20678			10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker			16b. Kind of Business/Industry own home			
17. Father's Name (First, Middle, Last) George Turner					18. Mother's Name (First, Middle, Maiden Surname) Virginia Lyles						
19a. Informant's Name/Relationship (Type, Print) niece Pattie Walker- daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 County St. Ipswich Ma 01938						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) Oct 14 2000 St. Pauls Epis. Cemetery			20c. Location - City or Town, State Prince Frederick MD			
21. Signature of Funeral Service Licensee B Rausch					22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SODEN CARDIAC ARRYTHMIA Ante respiratory Failure Due to (or as a consequence of): a. Ante respiratory Failure Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death minutes	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic urinary tract infection										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Robert Schlager					29c. License number D16823			29d. Date signed (Month, Day, Year) 10-11-2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT SCHLAGER, MD PRINCE FREDERICK, MD 20678											
31. Date filed (Month, Day, Year) OCT 16 2000			32. Registrar's Signature Benita B Sparks								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35529

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Viola Speaks		2. Date of Death Month Day Year October 22, 2000		3. Time of Death 9:50pm
	4a. Facility Name (If not institution, give street and number) 14448 Dorsey Mill Road		4b. City, Town, or Location of Death Glenwood		4c. County of Death Howard
Funeral Director	5. Social Security Number 412-24-1251	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth Month Day Year May 3, 1912		9. Birthplace (State or Foreign) Kentucky		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MD	10b. County Howard	10c. City, Town or Location Glenwood		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 14448 Dorsey Mill Road		10f. Zip Code 21738		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Domestic		
	17. Father's Name (First, Middle, Last) Dan Fee		18. Mother's Name (First, Middle, Maiden Surname) Sarah Neff		
	19a. Informant's Name/Relationship (Type, Print) Mrs. Betty Helton (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1614 Marshall Avenue, Rockville, MD 20851		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Memorial Gard		20c. Location - City or Town, State 10/26/00 Marriottsville, MD
	21. Signature of Funeral Service Licensee Brian L. Haight		22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC COLON CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 24 YEARS
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
State Registrar	29b. Signature and title of certifier [Signature]		29c. License number 025947		29d. Date signed (Month, Day, Year) OCTOBER 24, 2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene Jackson MD 5540 TEN OAKS RD CLARKSVILLE MD 21029				
State Registrar	31. Date filed (Month, Day, Year) OCT 25 2000		32. Registrar's Signature [Signature]		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35530

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Roger Smith				2. Date of Death Month Day Year OCTOBER 06, 2000		3. Time of Death 8:28PM	
	4e. Facility Name (If not institution, give street and number) St. Mary's Hospital				4b. City, Town, or Location of Death Leonardtwn		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 170-14-4843		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 78		8. Date of Birth (Month, Day, Year) October 19, 1921	
	Usual Residence of Decedent		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location California	
To Be Completed by Funeral Director	10e. Street and Number 24254 North Patuxent Beach Road		10f. Zip Code 20619		10g. Citizen of What Country? U S A		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 2 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telephone Repair Technician		16b. Kind of Business/Industry Telephone Company			
	17. Father's Name (First, Middle, Last) Guy Robert Smith				18. Mother's Name (First, Middle, Maiden Surname) Ivy Ella Rogers			
	19a. Informant's Name/Relationship (Type, Print) Catherine M. Smith (Spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20619 24254 North Patuxent Beach Road, California, Maryland			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Methodist Cemetery		20c. Location - City or Town, State 10/11/2000 Mechanicsville, Maryland			
	21. Signature of Funeral Service Licensee <i>Michael D. Gardner</i>				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Acute myocardial infarction</i> Due to (or as a consequence of): b. <i>Sepsis</i> Due to (or as a consequence of): c. <i>Ischemic Right foot</i> Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death 1 hr 3 days 1 month							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus</i> <i>Renal failure</i>							
Physician /Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>R. Gill</i>				29c. License number D 56096		29d. Date signed (Month, Day, Year) October 9, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. RAJBINDER S GILL HOLLYWOOD, MD 20636								
State Registrar	31. Date filed (Month, Day, Year) OCT 10 2000				32. Registrar's Signature <i>B. Sparks</i>			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 35531

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna L. Stoltzfus				2. Date of Death Month Day Year September 30, 2000				3. Time of Death 11:15 AM			
	4a. Facility Name (If not institution, give street and number) 37541 Grove Farm Lane				4b. City, Town, or Location of Death Mechanicsville				4c. County of Death St. Mary's			
Funeral Director	5. Social Security Number 220-55-3263		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 19 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.			
	8. Date of Birth (Month, Day, Year) May 26, 1981		9. Birthplace (State or Foreign Country) Maryland		Usual Residence of Decedent		10a. State Maryland		10b. County St. Mary's			
To Be Completed by Funeral Director	10c. City, Town or Location Mechanicsville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 37541 Grove Farm Lane			
	10f. Zip Code 20659				10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student				16b. Kind of Business/Industry School			
	17. Father's Name (First, Middle, Last) Daniel M. Stoltzfus				18. Mother's Name (First, Middle, Maiden Surname) Sarah S. Lapp				19a. Informant's Name/Relationship (Type, Print) Daniel M. Stoltzfus (Father)			
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37541 Grove Farm Lane, Mechanicsville, Maryland 20659				20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fisher Cemetery			
	20c. Date 10/3/2000				20d. Location - City or Town, State Mechanicsville, Maryland				21. Signature of Funeral Service Licensee <i>Michael Kevin Anderson</i>			
	22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Cardiopulmonary Failure</i> Due to (or as a consequence of): <i>General Anesthesia</i> Due to (or as a consequence of): <i>Pharyngobronchitis</i> Due to (or as a consequence of):				Approximate Interval Between Onset and Death <i>h7.</i> <i>4-24.</i> <i>life</i>			
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	29b. Signature and title of certifier <i>J. Patrick Jarboe MD</i>				29c. License number D 06419				29d. Date signed (Month, Day, Year) 10-2-00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Patrick Jarboe, MD Hollywood, Maryland 20636											
	31. Date filed (Month, Day, Year) OCT 3 2000				32. Registrar's Signature <i>B. Sparks</i>							

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene 00 35532

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Irvin H Smith</i>				2. Date of Death Month <i>October</i> Day <i>22</i> Year <i>2000</i>		3. Time of Death <i>0820</i>	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number <i>222-20-5063</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>64</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>July 23, 1936</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>
	Usual Residence of Decedent							
10a. State <i>Maryland</i>		10b. County <i>Wicomico</i>		10c. City, Town or Location <i>Salisbury</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <i>306 Penn Street</i>				10f. Zip Code <i>21801</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1960-65</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i></i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>laborer - maintenance</i>		16b. Kind of Business/Industry <i>Wicomico Youth & Civic Center</i>		
17. Father's Name (First, Middle, Last) <i>Clinton Smith</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Hattie Hudson</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Katie Smith/wife</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>306 Penn Street - Salisbury, MD 21801</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Springhill Memory Gardens</i>		20c. Location - City or Town, State <i>Hebron, Maryland</i>		
21. Signature of Funeral Service Licensee <i>Patricia A. Jolley</i>				22. Name and Address of Facility <i>1213 Jersey Road - Salisbury, MD</i> JOLLEY MEMORIAL CHAPEL 21801				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>myocardial cardiomyopathy</i> Due to (or as a consequence of): b. <i>coronary atherosclerosis</i> Due to (or as a consequence of): c. <i>Diabetes</i> Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>end-stage renal failure</i>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Constante J. Tan M.D.</i>				29c. License number <i>D 16725</i>		29d. Date signed (Month, Day, Year) <i>10/22/00</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Constante J. Tan M.D. 547 G Riverside Dr. Salisbury MD 21801</i>								
31. Date filed (Month, Day, Year) <i>OCT 25 2000</i>				32. Registrar's Signature <i>B. Sparks</i>				

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 35533

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN WILMER SUTTON			2. Date of Death Month: October Day: 21, Year: 2000		3. Time of Death 6:25 AM	
	4a. Facility Name (If not institution, give street and number) 703 College Lane, Apt. 2			4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 219-20-8565	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 12, 1925	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Wicomico	10c. City, Town or Location Salisbury		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 703 College Lane, Apt. 2		10f. Zip Code 21804		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clinical Psychologist		16b. Kind of Business/Industry Psychology		
	17. Father's Name (First, Middle, Last) John Weldon Sutton			18. Mother's Name (First, Middle, Maiden Surname) Bessie Belle Briddell			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Eloise R. Sutton/Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 College Lane, apt. 2, Salisbury, MD 21804			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Donation		20b. Place of Disposition (Name of cemetery, crematory or other place) Anatomical Board of Maryland		Data 10/21/00	20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd, Salisbury, MD 21804			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CANCER OF LUNG. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number D 32014		29d. Date signed (Month, Day, Year) 10/24/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHESH MOONINDRA MD 106 WILFORD ST 504 B SALISBURY MD 21804							
31. Date filed (Month, Day, Year) OCT 25 2000		32. Registrar's Signature 					

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State of Maryland / Department of Health and Mental Hygiene

00 35534

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM EDWARD SMOOT				2. Date of Death Month Day Year 10 19 2000		3. Time of Death 0043		
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO		
Funeral Director	5. Social Security Number 225-44-9397		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) February 9, 1936		
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury		
Usual Residence of Decedent									
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			10e. Street and Number 523 Buena Vista Ave.			10f. Zip Code 21804		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) -			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inspector			16b. Kind of Business/Industry Steel Mill			
17. Father's Name (First, Middle, Last) William Daniel Smoot				18. Mother's Name (First, Middle, Maiden Surname) Frances E Lois Smith					
19a. Informant's Name/Relationship (Type, Print) Deena Lane/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10232 Butler Rd., Newark, Ohio 43055					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 10/24/00		20c. Location - City or Town, State Salisbury, MD		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Myelodysplasia in Transformation</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Approximate Interval Between Onset and Death 3 months									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pneumonia</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and Title of certifier <i>[Signature]</i>			29c. License number 030690			29d. Date signed (Month, Day, Year) Oct. 19, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES MARTIN 145 E. CARROLL ST. SALISBURY, MD, 21801									
31. Date filed (Month, Day, Year) OCT 23 2000			32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

225-44-9397
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

William E. Smoot

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State of Maryland / Department of Health and Mental Hygiene

00 35535

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Earl Chester Savage

2. Date of Death

Month

Day

Year

Oct 26 2000

3. Time of Death

5:15 Am

4a. Facility Name (If not institution, give street and number)

Goodwill Mennonite Home

4b. City, Town, or Location of Death

Grantsville

4c. County of Death

Garrett

Funeral
Director

5. Social Security Number

220-10-1688

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 7, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

McHenry

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

375 Mosser Road

10f. Zip Code

21541

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

4+ years

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education (Public School)

17. Father's Name (First, Middle, Last)

Isaac Taylor Savage

18. Mother's Name (First, Middle, Maiden Surname)

Nora Blanche Kelly

19a. Informant's Name/Relationship (Type, Print)

Catherine E. Savage/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

375 Mosser Rd., McHenry, MD 21541

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Garrett Co. Mem. Gard. Oct 29, 2000

Date

20c. Location - City or Town, State

Oakland, MD

21. Signature of Funeral Service Licensee

A. Gurnea

22. Name and Address of Facility

Newman Funeral Homes, P.A., PO Box 275

179 Miller St., Grantsville, MD 21536

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Due to (or as a consequence of):

Approximate interval between Onset and Death

one week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Chronic obstructive Lung Disease

Due to (or as a consequence of):

5 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's disease.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. E. Blom

29c. License number

D 34079

29d. Date signed (Month, Day, Year)

Oct 27, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

James E. Butler MD Grantsville MD 21536

31. Date filed (Month, Day, Year)

OCT 30 2000

32. Registrar's Signature

A. Gurnea

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35536

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alfe ----- Sisler				2. Date of Death Month Day Year Oct. 29, 2000		3. Time of Death 8:00 AM						
	4a. Facility Name (If not institution, give street and number) Garrett County Memorial Hospital				4b. City, Town, or Location of Death Oakland		4c. County of Death Garrett						
Funeral Director	5. Social Security Number 213-34-5336		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 12, 1910	9. Birthplace (State or Foreign Country) West Virginia					
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State MD.		10b. County Garrett		10c. City, Town or Location Oakland			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	10e. Street and Number 849 Crellin Mine Road				10f. Zip Code 21550		10g. Citizen of What Country? USA						
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Home							
	17. Father's Name (First, Middle, Last) William Arnold Dumire				18. Mother's Name (First, Middle, Maiden Summa) Susan Caroline Shaffer								
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Hazel M. Teagarden/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 849 Crellin Mine Road, Oakland, Md. 21550								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrett Co. Mem. Gardens		Date 10/31/00		20c. Location - City or Town, State Oakland, Maryland						
	21. Signature of Funeral Service Licensee Bridley H. Stewart				22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Acute Lymphocytic Leukemia</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. Gram Negative Sepsis</td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Acute Lymphocytic Leukemia	Approximate Interval Between Onset and Death	b. Gram Negative Sepsis	c.
Immediate Cause (Final disease or condition resulting in death)	a. Acute Lymphocytic Leukemia	Approximate Interval Between Onset and Death											
	b. Gram Negative Sepsis												
	c.												
	d.												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown													
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred									
28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier Sotiere Savopoulos				29c. License number 042464		29d. Date signed (Month, Day, Year) 10/27/00							
30. Name and address of person who completed cause of death (item 23a) (Type, Print) Sotiere Savopoulos MD Rt. 1 Box 5All, Terra Alta, WV 26764													
31. Date filed (Month, Day, Year) OCT 30 2000		32. Registrar's Signature B. Spade											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35537

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty Viola Simpson				2. Date of Death Month Day Year OCTOBER 19, 2000				3. Time of Death 2:15 P.M.		
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland				4c. County of Death Allegany		
Funeral Director	5. Social Security Number 215-16-4044		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 27, 1921		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State MD.		10b. County Allegany		10c. City, Town or Location Rawlings				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 18312 McMullen Highway				10f. Zip Code 21557				10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales				16b. Kind of Business/Industry Department Store			
17. Father's Name (First, Middle, Last) John W. Patton				18. Mother's Name (First, Middle, Maiden Surname) Viola P. Smiley							
19a. Informant's Name/Relationship (Type, Print) Walter Simpson/husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18312 McMullen Hwy., Rawlings Md., 21557							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Lawn Mem. Gardens		Date 10/21/00		20c. Location - City or Town, State LaVale, Maryland			
21. Signature of Funeral Service Licensee F. Wayne Boal				22. Name and Address of Facility Boal Funeral Home 111 Church St., Westernport, Maryland 21562							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cardiac Arrhythmia</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 24 Hours	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Renovascular Disease with GVO</u> <u>Stage Renal Disease; Hypertension;</u> <u>Tuberculosis, colitis</u>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Robert Welik				29c. License number D31875			
				29d. Date signed (Month, Day, Year) OCTOBER 19, 2000							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Welik 902 Seton Drive, Cumberland, Maryland 21502											
31. Date filed (Month, Day, Year) OCT 20 2000				32. Registrar's Signature S. Sparks							

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35538

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carol Lillian Stephens				2. Date of Death Month 10 Day 10 Year 2000				3. Time of Death 8:50 a.m.	
	4a. Facility Name (If not institution, give street and number) Garrett County Memorial Hospital				4b. City, Town, or Location of Death Oakland				4c. County of Death Garrett	
Funeral Director	5. Social Security Number 578-40-6578		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) March 20, 1928		9. Birthplace (State or Foreign Country) Massachusetts		10a. State MD		10b. County Garrett		10c. City, Town or Location Friendsville	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 299 Cherry Lane Road		10f. Zip Code 21531		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 yrs. College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant		16b. Kind of Business/Industry Montgomery Co. Board of Education		17. Father's Name (First, Middle, Last) Carl A. Johnson		18. Mother's Name (First, Middle, Maiden Surname) Susie E. Snelgrove		19a. Informant's Name/Relationship (Type, Print) Herbert G. Stephens/husband		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 299 Cherry Lane Road, Friendsville, MD 21531		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Country Side Crem.		Date Oct 11, 2000		20c. Location - City or Town, State Davidsville, PA		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or organ failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. pancreatic cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 3 mo				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D30035		29d. Date signed (Month, Day, Year) 10-10-2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donald R. Richter, M.D. 1533 Memorial Drive Oakland, MD 21550		31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

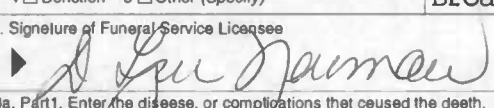
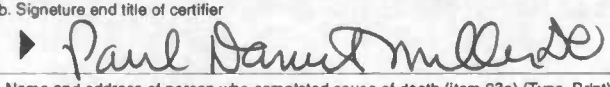
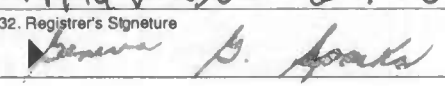
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35539

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Freda May Smith				2. Date of Death Month Day Year 10 07 00		3. Time of Death 11 15 AM	
	4a. Facility Name (If not institution, give street and number) Garrett County Memorial				4b. City, Town, or Location of Death Oakland		4c. County of Death Garrett	
Funeral Director	5. Social Security Number 165-52-9766		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug 4, 1930	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State PA		10b. County Fayette		10c. City, Town or Location Ohiopyle		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 459 Bell Grove Road				10f. Zip Code 15470		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Laurence Smith				18. Mother's Name (First, Middle, Maiden Surname) Malinda Wilt				
19a. Informant's Name/Relationship (Type, Print) Mary Jane Smith/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 459 Bell Grove Road, Ohioypyle, PA 15470				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Broadwater Cem., Oct 9, 2000		20c. Location - City or Town, State Swanton, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Newman Funeral Homes, P.A., 179 Miller St. P.O. Box 275, Grantsville, MD 21536				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. arteriosclerotic coronary vascular disease Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death Minutes		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury of Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number H 76 154		29d. Date signed (Month, Day, Year) 10/8/00
30. Name and address of person who completed cause of death (item 23a) (Type, Print) Paul Daniel Miller DO				31. Date filed (Month, Day, Year) OCT 12 2000				
32. Registrar's Signature 				33. Date of Death (Month, Day, Year) 10/8/00				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35540

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sarah Elizabeth Spiker				2. Date of Death Month Day Year Oct. 10, 2000		3. Time of Death 4:52 AM	
	4a. Facility Name (If not institution, give street and number) Dennett Road Manor Nursing Home				4b. City, Town, or Location of Death Oakland		4c. County of Death Garrett	
Funeral Director	5. Social Security Number 220-26-9838	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 18, 1908		9. Birthplace (State or Foreign Country) Georgia
	Usual Residence of Decedent							
10a. State MD		10b. County Garrett		10c. City, Town or Location Oakland		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 965 Dennett Road				10f. Zip Code 21550		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4or 5+) 7th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse's Aide		16b. Kind of Business/Industry Hospital		
17. Father's Name (First, Middle, Last) Andrew Jackson Logan				18. Mother's Name (First, Middle, Maiden Surname) William Piety Sargent				
19a. Informant's Name/Relationship (Type, Print) Betty K. Trickett/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 965 Dennett Road, Oakland, Maryland 21550				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Pleasant Valley Cemetery		20c. Location - City or Town, State Oakland, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) coronary heart disease Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death 20 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. congestive heart failure						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D27205		29d. Date signed (Month, Day, Year) 10/10/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karl E. Schwalm M.D. 311 N. 4th St., Oakland, Md. 21550								
31. Date filed (Month, Day, Year) OCT 11 2000				32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35541

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eleanor R. Taylor				2. Date of Death Month Day Year October 22, 2000		3. Time of Death 10:00 AM	
	4a. Facility Name (If not institution, give street and number) Maplewood Park Place Health Care				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 082-07-5724		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) August 14, 1915	
	9. Birthplace (State or Foreign Country) New Jersey		10a. State N/A		10b. County N/A		10c. City, Town or Location Washington, D.C.	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10a. Street and Number 3409 Lowell Street, N.W.		10f. Zip Code 20016		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) Raymond Temple	
	18. Mother's Name (First, Middle, Maiden Surname) Alice Mulrey		19a. Informant's Name/Relationship (Type, Print) Holly R. Nelson/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3409 Lowell Street, N.W., Washington, D.C. 20016		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		20c. Location - City or Town, State Bethesda, Maryland		21. Signature of Funeral Service Licensee M01126		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebral Hemorrhage Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27a. Date of Injury (Month, Day Year)		27b. Time of Injury M	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier A. Kaufman		29c. License number D26259		29d. Date signed (Month, Day, Year) October 23, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ava A. Kaufman, M.D. 4930 Del Ray Avenue #403, Bethesda, Maryland 20814	
State Registrar	31. Date filed (Month, Day, Year) OCT 25 2000		32. Registrar's Signature B. Sparks		33. Date of Death (Month, Day, Year) October 22, 2000		34. Time of Death 10:00 AM	

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35542

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DORIS BROWN TOOLE

2. Date of Death
Month Day Year
October 20, 20003. Time of Death
3:30 PM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-18-7074

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

September 10 1920

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13500 Columbia Road

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Roland M. Brown

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Troupe

19a. Informant's Name/Relationship (Type, Print)

Michael D. Toole/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8578 Yoder Street, Manassas, VA 20110

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

10/24/00

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Murphy Falls Church Funeral Home

1102 W. Broad Street, Falls Church, VA 22046

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e.

Myocardial Infarction

Due to (or as a consequence of):

b.

Hypoxic Respiratory Failure

Due to (or as a consequence of):

c.

Pulmonary Malignancy

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending
investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, term, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)

29b. Signature and title of certifier

29c. License number

D57908

29d. Date signed (Month, Day, Year)

October 20 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Maschare 1814 Prince Philip Drive Olney Maryland 20855

31. Date filed (Month, Day, Year)

OCT 23 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35543

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CON, HE R. Thompson

2. Date of Death

10 10 2000 sam

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Charlotte Hall Veterans Home

4b. City, Town, or Location of Death

Charlotte Hall

4c. County of Death

St Mary's

5. Social Security Number

228-10-4695

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

04, 20, 1917

9. Birthplace (State or Foreign Country)

Louisiana

Usual Residence of Decedent

10a. State

Md. St Mary

10b. County

10c. City, Town or Location

Charlotte Hall

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

29444 Charlotte Hall Road

10f. Zip Code

20622

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates: 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

GOVERNMENT

16b. Kind of Business/Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

Freddie Thompson

18. Mother's Name (First, Middle, Maiden Surname)

Alice Terrell

19a. Informant's Name/Relationship (Type, Print)

Cecil Thompson Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1128 James Madison Hwy Gordonsville, Va 22942

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Culpeper National Cemetery

Date

10/13/00

20c. Location - City or Town, State

Culpeper Va.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Thompson Funeral Service

Do Not Sign Here

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Moderately differentiated adenocarcinoma of - 1 year.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. - Stomach -

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Gyan C. Surana

29c. License number

D.50653

29d. Date signed (Month, Day, Year)

10-11-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5851-Dealechurchton Road, Deale, MD 20751

31. Date filed (Month, Day, Year)

OCT 11 2000

32. Registrar's Signature

[Signature]

State
Registrar

ORIGINAL

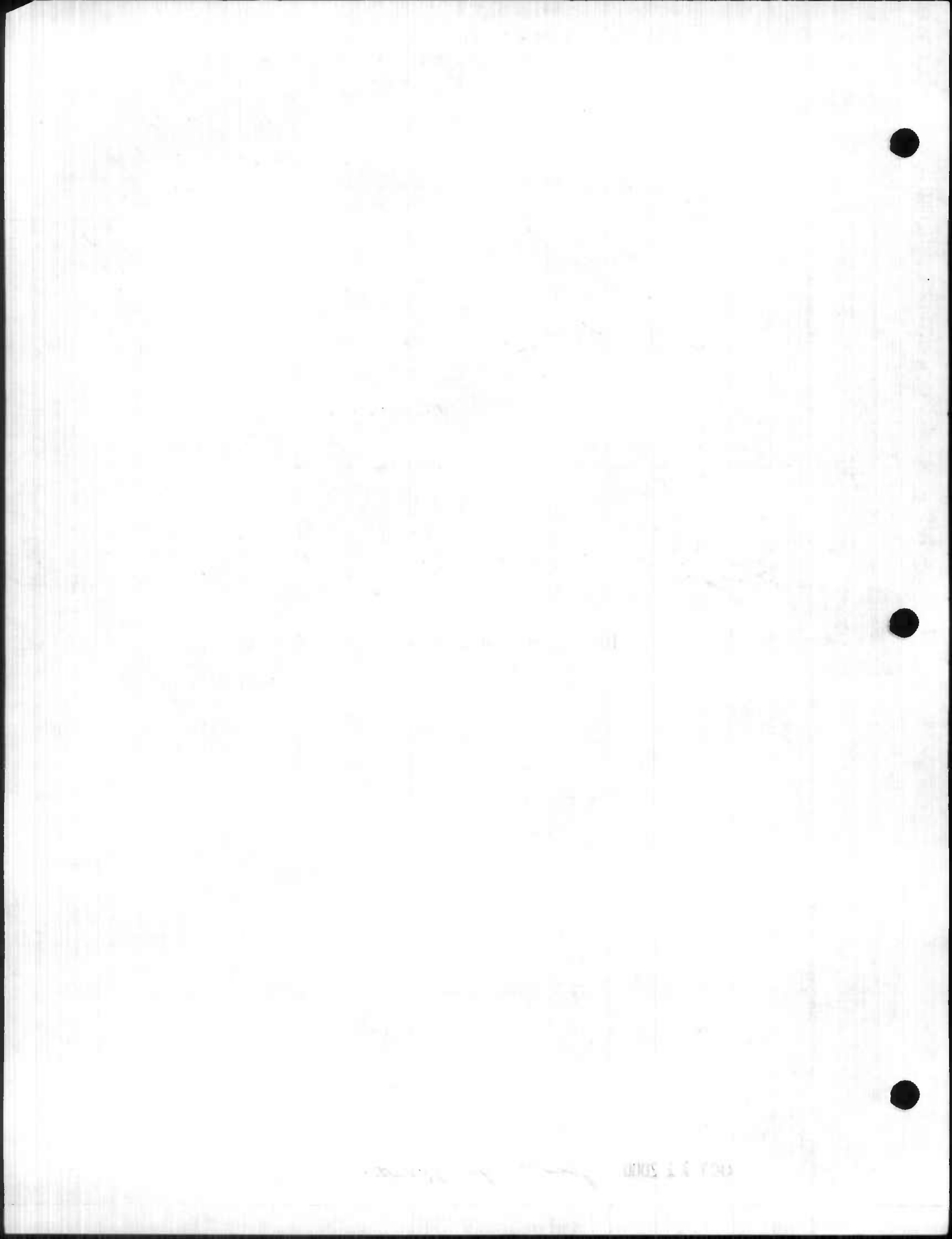
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35544

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHINH THI TRAN				2. Date of Death Month Day Year October 22, 2000		3. Time of Death 1345	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 220-08-6656	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12-31-27		9. Birthplace (State or Foreign Country) VIETNAM
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County DORCHESTER	10c. City, Town or Location HURLOCK			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 102-GAY ST (P.O. BOX 472)			10f. Zip Code 21643		10g. Citizen of What Country? VIETNAM		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: VIETNAMESE		14. Race - American Indian, Black, White, etc. Specify: VIETNAMESE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NONE		16b. Kind of Business/Industry NONE			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) SEN TRAN				18. Mother's Name (First, Middle, Maiden Surname) NOI THI LY			
	19a. Informant's Name/Relationship (Type, Print) TOI NGOC TU - HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102-GAY ST. (PO BOX 472) HURLOCK, MD, 21643			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CAPITAL CREMATORY		20c. Location - City or Town, State DOVER, DE.		20d. Date 10/25/00	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility BENDIE SMITH F.H. 917 W. ISABELLA ST. SALISBURY, MD 21801					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Renal Failure Due to (or as a consequence of): b. Myocardial Infarction Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. Diabetes Mellitus c. Hypertension b. Heart Failure a. Parkinson's Disease							Approximate Interval Between Onset and Death week, week,
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. d. Diabetes Mellitus c. Hypertension b. Heart Failure a. Parkinson's Disease							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 10/23/00		29c. License number 044069		29d. Date signed (Month, Day, Year) 10-23-00			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH LINDSEY JR 106 MILFORD RD SALISBURY MD 21804							
	31. Date filed (Month, Day, Year) OCT 24 2000		32. Registrar's Signature 					

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35545

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carroll Louis Uebel				2. Date of Death Month: October Day: 21 st Year: 2000		3. Time of Death 6:35 PM		
	4a. Facility Name (If not institution, give street and number) Carroll County General Hospital				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll		
Funeral Director	5. Social Security Number 219-10-6504		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) April 23, 1915		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Carroll		10c. City, Town or Location Taneytown		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2833 Kump Station Road		10f. Zip Code 21787		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 6 College (1-4 or 5+):		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer		16b. Kind of Business/Industry Agriculture					
17. Father's Name (First, Middle, Last) Louis Charles Uebel				18. Mother's Name (First, Middle, Maiden Surname) Katherine Kroner					
19a. Informant's Name/Relationship (Type, Print) Mrs. Carol Bellomy (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2340-B Sandymount Road Finksburg, MD 21048					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park		20c. Date 10/24/00		20d. Location - City or Town, State Elkridge, MD			
21. Signature of Funeral Service Licensee Brian A. Haight				22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, P.A. (Box 195) Sykesville, MD 21784 (410)-795-1400					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature], MD		29c. License number D48006		29d. Date signed (Month, Day, Year) October 21 st , 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOFI BOATEY, 200 Memorial Ave, Westminster, MD 21157									
31. Date filed (Month, Day, Year) OCT 24 2000		32. Registrar's Signature [Signature]							

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State of Maryland / Department of Health and Mental Hygiene

00 35546

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carlos R. Valverde				2. Date of Death Month Day Year October 22, 2000				3. Time of Death 8:30 PM		
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 515-62-2929		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 43 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 9, 1957		9. Birthplace (State or Foreign Country) Missouri		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Olney				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 17212 Sandy Knoll Drive				10f. Zip Code 20832		10g. Citizen of What Country? USA				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Mexican				14. Race - American Indian, Black, White, etc. Specify: Hispanic		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrical Engineer				16b. Kind of Business/Industry Applied Physics Lab		
	17. Father's Name (First, Middle, Last) Carlos Valverde				18. Mother's Name (First, Middle, Maiden Surname) Peggy Rose						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Susan Valverde / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17212 Sandy Knoll Drive, Olney, Maryland 20832						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Everly Crematory		20c. Date 10/26/00		20d. Location - City or Town, State Fairfax, Virginia				
	21. Signature of Funeral Service Licensee ▶ Alany Donnell				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Recurrent Obstructive Pulmonary Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death Two Years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
State Registrar	29b. Signature and title of certifier ▶ [Signature]				29c. License number 033686				29d. Date signed (Month, Day, Year) October 29, 2000		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth M. [Signature] 1811 Pine Phib Dr. Olney, MD 20832										
31. Date filed (Month, Day, Year) OCT 25 2000		32. Registrar's Signature ▶ [Signature]									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35547

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Milton Warren						2. Date of Death Month Day Year October 20, 2000		3. Time of Death 10:58 AM																	
	4a. Facility Name (If not institution, give street and number) 2610 Kirtland Avenue						4b. City, Town, or Location of Death District Heights		4c. County of Death Prince Georges																	
Funeral Director	5. Social Security Number 456-05-8864		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) July 23, 1913		9. Birthplace (State or Foreign Country) Texas																	
	Usual Residence of Decedent																									
10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location District Heights				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																		
10e. Street and Number 2610 Kirtland Avenue						10f. Zip Code 20747		10g. Citizen of What Country? United States																		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black																		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor			16b. Kind of Business/Industry Government																			
17. Father's Name (First, Middle, Last) Archie A. Warren						18. Mother's Name (First, Middle, Maiden Surname) Joanna Tivis																				
19a. Informant's Name/Relationship (Type, Print) Joseph M. Warren, Jr. Son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2610 Kirtland Ave., District Heights, MD 20747																				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Rock Creek Cemetery		Date 10/27/00		20c. Location - City or Town, State Washington, D.C.																		
21. Signature of Funeral Service Licensee Thomas S. Clyburn						22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012																				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																										
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Carcinoma of Pancreas</td> <td>Approximate Interval Between Onset and Death 2 months</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="3"></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Carcinoma of Pancreas	Approximate Interval Between Onset and Death 2 months	Due to (or as a consequence of):			b.	Due to (or as a consequence of):		c.	Due to (or as a consequence of):		d.			
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Carcinoma of Pancreas	Approximate Interval Between Onset and Death 2 months																							
	Due to (or as a consequence of):																									
	b.	Due to (or as a consequence of):																								
	c.	Due to (or as a consequence of):																								
d.																										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																										
<table border="1"> <tr> <td>Hypertension</td> <td>23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</td> </tr> <tr> <td>Hypothyroidism</td> <td>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> <tr> <td>Dementia</td> <td>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>										Hypertension	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	Hypothyroidism	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Dementia	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
Hypertension	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																									
Hypothyroidism	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																									
Dementia	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred																		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																										
29b. Signature and title of certifier Suresha Patel						29c. License number D46978		29d. Date signed (Month, Day, Year) October 23, 2000																		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresha Patel, M.D. 7501 Surratts Road, Clinton, MD 20735																										
31. Date filed (Month, Day, Year) OCT 25 2000		32. Registrar's Signature S. Sparks																								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,


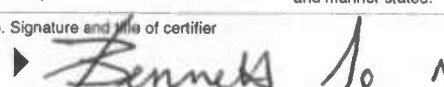

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State of Maryland / Department of Health and Mental Hygiene

00 35548

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Kieffer Will				2. Date of Death Month 10 Day 20 Year 2000		3. Time of Death 1:20p	
	4a. Facility Name (If not institution, give street and number) Fairland Adventist Nursing & Rehabilitation Center				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579 36 6108		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 24, 1929	
	9. Birthplace (State or Foreign Country) Virginia							
Usual Residence of Decedent								
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Takoma Park			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 703 Boston Avenue				10f. Zip Code 20912		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1949-1951		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Collage (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plant Operator		16b. Kind of Business/Industry Water Treatment Plant		
17. Father's Name (First, Middle, Last) Herman Kieffer Will				18. Mother's Name (First, Middle, Maiden Surname) May Lee Weymouth				
19a. Informant's Name/Relationship (Type, Print) Gloria May Will / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 Boston Avenue, Takoma Park, Maryland 20912				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date October 21, 2000		20c. Location - City or Town, State Alexandria, Virginia		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 20901 500 University Boulevard, W., Silver Spring, MD				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 4 mos
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and Title of certifier  Bennett So MD				29c. License number D54488		29d. Date signed (Month, Day, Year) 10/20/2000		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Bennett So, MD, 8317 Cherry Ln, Laurel, MD 20707								
31. Date filed (Month, Day, Year) OCT 23 2000				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35549

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Olivia Beatrice

Wilson

2. Date of Death

Month Day Year

October 16 2000

3. Time of Death

715pm

4a. Facility Name (If not institution, give street and number)

907 Davis Avenue

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

220-34-8004

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 1, 1914

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

907 Davis Ave

10f. Zip Code

20912

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Health-care

17. Father's Name (First, Middle, Last)

Charles Gustafson

18. Mother's Name (First, Middle, Maiden Surname)

Amelia Larson

19a. Informant's Name/Relationship (Type, Print)

Verne Wilson /Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

907 Davis Ave, Takoma Park, MD 20912

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parklawn Memorial Park

Date

Oct 25
2000

20c. Location - City or Town, State

Rockville, MD

21. Signature of Funeral Service Licensee

David L. Hahn

22. Name and Address of Facility

Rapp Funeral & Cremation Services
933 Gist Avenue Silver Spring, MD23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Congestive Heart Failure

Approximate
Interval Between
Onset and Death

2 years

a. Due to (or as a consequence of):

Atrial Fibrillation

2 years

b. Due to (or as a consequence of):

Essential Hypertension

c. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus, obesity

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

David K. Cromwell, M.D.

29c. License number

003835

29d. Date signed (Month, Day, Year)

October 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David K. Cromwell, M.D. 831 University Blvd.-East #37; Silver Spring, MD 20903-2998

31. Date filed (Month, Day, Year)

OCT 23 2000

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
card.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35550

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Kemp Woodworth				2. Date of Death Month Day Year October 19, 2000		3. Time of Death 3:00 PM		
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 292-12-0125	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 23, 1923		9. Birthplace (State or Foreign Country) Ohio	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 7606 Holiday Terrace				10f. Zip Code 20817		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrical Engineer		16b. Kind of Business/Industry Communications		
	17. Father's Name (First, Middle, Last) Joseph Grant Woodworth				18. Mother's Name (First, Middle, Maiden Surname) Helen E. Waldorf				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Cynthia Woodworth / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1136 Gratton Hill Rd., West Charleston, VT 05872				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory Inc.		Date Oct. 24		20c. Location - City or Town, State Beltsville, MD		
	21. Signature of Funeral Service Licensee Beverly E. Hecht				22. Name and Address of Facility Rapp Funeral and Cremation Services Stephen D. Lohrmann P.A. 933 Gist Ave., Silver Spring, MD 20910				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION PNEUMONIA Due to (or as a consequence of): b. METASTATIC LUNG CANCER Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Alpina Goswami M.D. INTERNSIST				29c. License number D-27660		29d. Date signed (Month, Day, Year) 10/20/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALPANA GOSWAMI M.D. 10901 CONNETT AVE, KENSINGTON MD 20895									
31. Date filed (Month, Day, Year) OCT 24 2000		32. Registrar's Signature B. Sparks							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35551

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DeMARCO IGNATIUS WELLS				2. Date of Death Month Day Year October 24, 2000				3. Time of Death 5:59 A.M.	
	4a. Facility Name (If not institution, give street and number) South Bound Route 5 at Carrico Mill Road				4b. City, Town, or Location of Death Hughesville				4c. County of Death Charles	
Funeral Director	5. Social Security Number 220-86-3114		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 26 Yrs.		8. Date of Birth (Month, Day, Year) AUG. 29, 1974		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
10a. State MARYLAND		10b. County ST. MARY'S		10c. City, Town or Location HOLLYWOOD				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 24952 PINTO DRIVE				10f. Zip Code 20636				10g. Citizen of What Country? UNITED STATES		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ASSISTANT PLUMBER				16b. Kind of Business/Industry PLUMBING		
17. Father's Name (First, Middle, Last) ROOSEVELT LEE				18. Mother's Name (First, Middle, Maiden Surname) MARY DORLISE WELLS						
19a. Informant's Name/Relationship (Type, Print) MARY D. WELLS / MOTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13135 GUY WASHINGTON ROAD, NEWBURG, MARYLAND 20664						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) HOLY GHOST CHURCH CEM.		20c. Date 10/30/00		20d. Location - City or Town, State ISSUE, MARYLAND		
21. Signature of Funeral Service Licensee LYDIA C. THORNTON JOHNSON M00583				22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene										
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 10/24/00		28b. Time of Injury 5:50AM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Passenger of vehicle that overturned		
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Joseph Pestaner M.D.		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) October 25, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) OCT 27 2000		32. Registrar's Signature B. Spence								

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

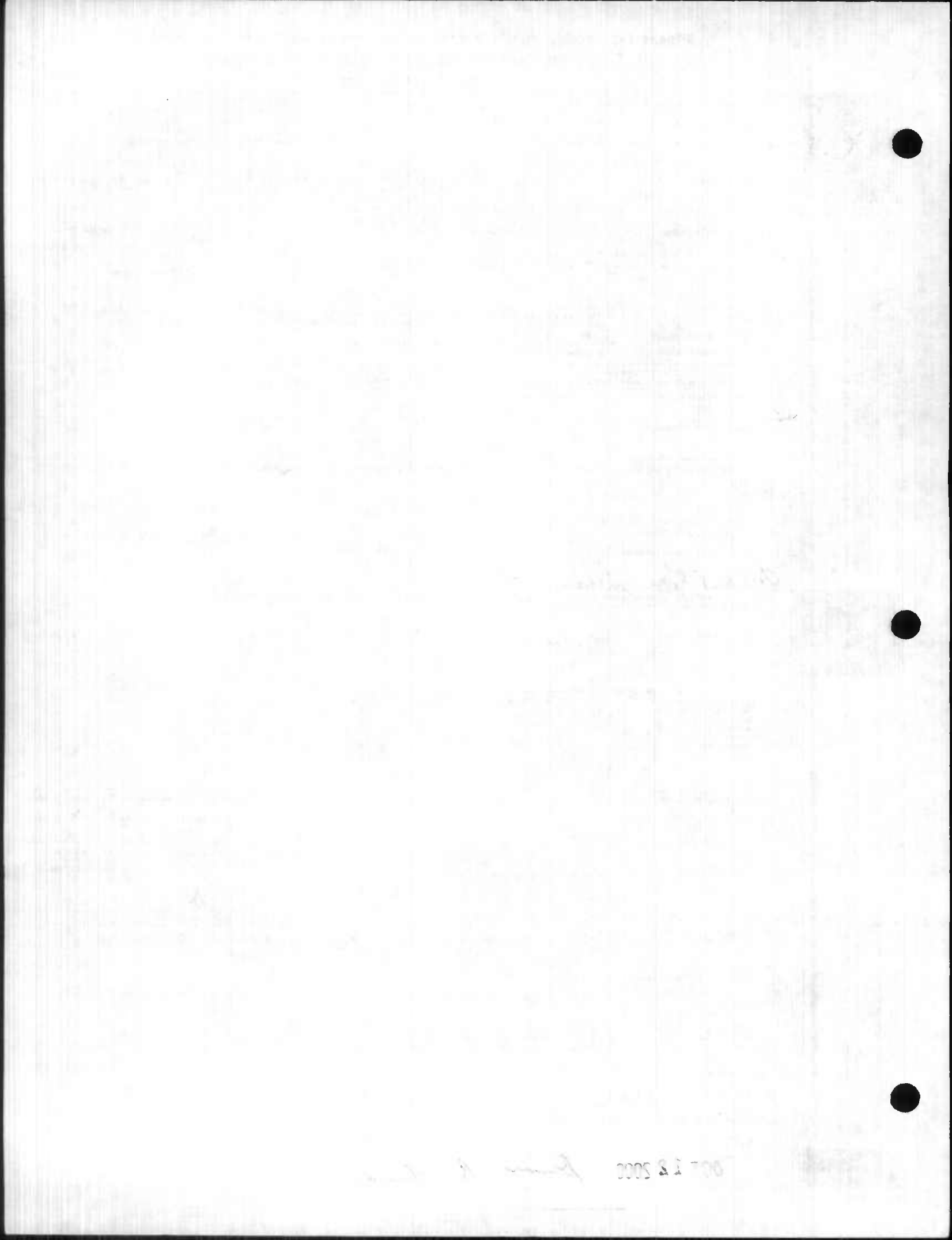
State of Maryland / Department of Health and Mental Hygiene

00 35552

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Dorene Windsor				2. Date of Death Month Day Year October 9, 2000		3. Time of Death 3:05 AM	
	4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center				4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 220-32-6987	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 9, 1935		9. Birthplace (State or Foreign Country) Washington, DC
	Usual Residence of Decedent							
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Hollywood			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 24484 Hollywood Road				10f. Zip Code 20636		10g. Citizen of What Country? U S A		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress			16b. Kind of Business/Industry Restaurant	
17. Father's Name (First, Middle, Last) Joseph Anthony Sincavage				18. Mother's Name (First, Middle, Maiden Surname) Nellie Smith				
19a. Informant's Name/Relationship (Type, Print) Angela D. Quade (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24484 Hollywood Road, Hollywood, Maryland 20636				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Memorial Gardens		20c. Location - City or Town, State 10/13/2000 Leonardtown, Maryland		
21. Signature of Funeral Service Licensee <i>Michael Kevin Sheridan</i>				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>metastatic ca of larynx</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death <i>few years</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>A. D. Shah</i>				29c. License number D 47066		29d. Date signed (Month, Day, Year) 10.9.00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A.D. Shah, MD Leonardtown, Maryland 20650								
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature <i>B. Spahr</i>				



Oct 18 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35553

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edith Russell Wilson				2. Date of Death Month Day Year OCTOBER 07, 2000		3. Time of Death 4:16AM										
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital				4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary's										
Funeral Director	5. Social Security Number 577-12-3337		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) August 1, 1919										
	Usual Residence of Decedent		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Leonardtown										
To Be Completed by Funeral Director	10e. Street and Number 22680 Cedar Lane Court # 212		10f. Zip Code 20650		10g. Citizen of What Country? U S A		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Commercial Artist		16b. Kind of Business/Industry Art												
	17. Father's Name (First, Middle, Last) Benjamin Dawson Russell				18. Mother's Name (First, Middle, Maiden Surname) Mignonette Mary Hayden												
	19a. Informant's Name/Relationship (Type, Print) Dorothy R. Richeson (Sister)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 West Princeton Cr., #4 Lynchburg, Virginia 24504												
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery		20c. Location - City or Town, State 10/10/2000 Lynchburg, Virginia												
	21. Signature of Funeral Service Licensee <i>Michael B. Gardner</i>				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>Acute Myocardial infarction</u></td> <td>Approximate Interval Between Onset and Death 2 hours</td> </tr> <tr> <td>b. <u>Recurrent seizures</u></td> <td>2 days</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <u>Acute Myocardial infarction</u>	Approximate Interval Between Onset and Death 2 hours	b. <u>Recurrent seizures</u>	2 days	c.		d.	
	Immediate Cause (Final disease or condition resulting in death)	a. <u>Acute Myocardial infarction</u>	Approximate Interval Between Onset and Death 2 hours														
b. <u>Recurrent seizures</u>		2 days															
c.																	
d.																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <table border="1"> <tr> <td>23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</td> <td>24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td>24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No															
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No <table border="1"> <tr> <td colspan="2">26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</td> </tr> </table>								26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined <table border="1"> <tr> <td>28a. Date of Injury (Month, Day Year)</td> <td>28b. Time of Injury M</td> <td>28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> <td>28d. Describe how injury occurred</td> </tr> <tr> <td colspan="3">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td>28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>								28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred														
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. Signature and title of certifier <i>ASuah</i>				29c. License number D 47066		29d. Date signed (Month, Day, Year) 10.7.00											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. AVANI D. SHAH HOLLYWOOD, MS. 20636																	
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature <i>B. Sparks</i>															

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35554

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM REGINALD WARD				2. Date of Death Month Day Year October 18, 2000				3. Time of Death 2:55 PM	
	4a. Facility Name (If not institution, give street and number) 4421 Smith Road				4b. City, Town, or Location of Death Salisbury				4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 213-16-8504		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) December 2, 1924		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 4421 Smith Rd.				10f. Zip Code 21801	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Army WW II	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) -	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Rural Mail Carrier				16b. Kind of Business/Industry U.S. Postal Service				17. Father's Name (First, Middle, Last) William A. Ward	
	18. Mother's Name (First, Middle, Maiden Surname) Lillian Fleming				19a. Informant's Name/Relationship (Type, Print) William Ward/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4421 Smith Rd., Salisbury, MD 21801	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Portersville Church Cemetery				20c. Location - City or Town, State 10/21/00 Stockton, MD	
	21. Signature of Funeral Service Licensee Kurt R. Hemeny				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Ischemic Dilated Cardiomyopathy Due to (or as a consequence of): b. Congestive Heart Failure Due to (or as a consequence of): c. Insulin Dependent Diabetes Mellitus Due to (or as a consequence of): d.	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier DO				29c. License number H54827	
	29d. Date signed (Month, Day, Year) 10/19/00				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MURIEL G. GRIFFIN, JR. 106 MILFORD ST SUITE 201 SALISBURY MD 21804				31. Date filed (Month, Day, Year) OCT 25 2000	
	32. Registrar's Signature S. Sparks				33. State Registrar				34. Date of Death OCT 18 2000	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35555

Amended #5, 10e, 20c/10-24-2000/WCHD Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy A. Waterhouse

2. Date of Death

OCTOBER 21, 2000 11:30 P

4a. Facility Name (If not institution, give street and number)

SALISBURY CENTER: GENESIS ELDERCARE

4b. City, Town, or Location of Death

SALISBURY, MD

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

230-01-0377

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 27, 1913

9. Birthplace (State or Foreign Country)

Del

Usual Residence of Decedent

10a. State

VA.

10b. County

Accomack

10c. City, Town or Location

Chincoteague

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6416 Jester St

10f. Zip Code

23336

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Self

17. Father's Name (First, Middle, Last)

Edward McCabe

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Daisy

19a. Informant's Name/Relationship (Type, Print)

Edward Waterhouse / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7930 Caminito Chis San Diego Calif. 92131

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Downing Cemetery

Date

10-25-2000

20c. Location - City or Town, State

Oak Hall Va
Oak Hall

21. Signature of Funeral Service Licensee

Constance Dodge Gordon Bailey

22. Name and Address of Facility

Salzer Funeral Home, 6927 Church St, Chincoteague Va

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 mos.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. cerebral infarct

Due to (or as a consequence of):

9 mos.

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William Robins, M.D.

29c. License number

D-29349

29d. Date signed (Month, Day, Year)

10/25/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM ROBINS, M.D. 1104 HEALTHWAY DR., SALISBURY, MD

31. Date filed (Month, Day, Year)

OCT 24 2000

32. Registrar's Signature

B. Sparks

State
RegistrarDOROTHY ANNIE WATERHOUSE
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35556

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARNOLD WHITEHAIR				2. Date of Death Month Day Year 9/27/2000				3. Time of Death 10:45am		
	4a. Facility Name (If not institution, give street and number) Garrett County Memorial Hospital				4b. City, Town, or Location of Death Oakland				4c. County of Death Garrett		
Funeral Director	5. Social Security Number 232-22-2635		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) 8/28/1912		9. Birthplace (State or Foreign Country) Terra Alta, WV		
	10a. State WV				10b. County Preston		10c. City, Town or Location Terra Alta				
10e. Street and Number Rt 1 Box 124				10f. Zip Code 26764				10g. Citizen of What Country? U.S.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer				16b. Kind of Business/Industry Agriculture			
17. Father's Name (First, Middle, Last) James R. Whitehair				18. Mother's Name (First, Middle, Maiden Surname) Myrta Garner Whitehair							
19a. Informant's Name/Relationship (Type, Print) Maxine Whitehair/Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt 1 Box 124, Terra Alta, WV 26764							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Terra Alta Cemetery				20c. Location - City or Town, State 9/30/2000 Terra Alta, WV			
21. Signature of Funeral Service Licensee Mark C. Spear				22. Name and Address of Facility Arthur H. Wright Funeral Home 105 Highland Avenue Terra Alta, WV 26764							
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia				Due to (or as a consequence of):				Approximate Interval Between Onset and Death 3d			
23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Due to (or as a consequence of):							
23c. Due to (or as a consequence of):											
23d. Due to (or as a consequence of):											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic lymphocyte lymphoma				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier [Signature]				29c. License number D17374		29d. Date signed (Month, Day, Year) 9/28/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sotiere Savopoulos MD - Rt 1 Box 5A-1 Terra Alta, WV 26764				31. Data filed (Month, Day, Year) OCT - 2 2000				32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35557

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Violet Rose Wilhelm						2. Date of Death Month Day Year September 30 2000		3. Time of Death 6:10AM	
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital						4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 214-46-3200		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81		8. Date of Birth (Month, Day, Year) Jan 26, 1919		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State MD		10b. County Garrett		10c. City, Town or Location Lonaconing				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 8590 Avilton-Lonaconing Road				10f. Zip Code 21539		10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Otha S. Fike						18. Mother's Name (First, Middle, Maiden Surname) Linnie E. Weitzell				
19a. Informant's Name/Relationship (Type, Print) Asa E. Wilhelm/husband						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8590 Avilton-Lonaconing Rd., Lonaconing, MD 21539				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Blocher Cem.		Date Oct 2, 2000		20c. Location - City or Town, State Frostburg, MD		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Large Right Thalamic intraventricular Hemorrhage Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death 9 days.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>S. Changin</i>				29c. License number D256 38		
				29d. Date signed (Month, Day, Year) September 30, 2000						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SATURNIA CHANDM.D. 10701 New Kings Creek S.W. Suit 3 Frostburg Maryland 21532										
31. Date filed (Month, Day, Year) OCT - 2 2000				32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35558

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred York				2. Date of Death Month October Day 22 , Year 2000		3. Time of Death 12:55 P.		
	4a. Facility Name (If not institution, give street and number) Hebrew Home of Greater Washington				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 078-18-1878		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 29, 1924		
	9. Birthplace (State or Foreign Country) New York		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Greenbelt		
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 21-L Ridge Road		10f. Zip Code 20770		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Legal Secretary		16b. Kind of Business/Industry Law Firm				
	17. Father's Name (First, Middle, Last) Samuel Zingman				18. Mother's Name (First, Middle, Maiden Surname) Sarah unk				
	19a. Informant's Name/Relationship (Type, Print) Brian York (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King David Memorial Garden		Date 10/24/00		20c. Location - City or Town, State Falls Church, Va.		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia								
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <i>Gregory A. Compton MD</i>				29c. License number D24942		29d. Date signed (Month, Day, Year) OCT 23, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregory A. Compton MD 6124 Montrose Rd Rockville MD 20852									
State Registrar	31. Date filed (Month, Day, Year) OCT 26 2000				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35559

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BELLE H. ZVARES

2. Date of Death

Month Day Year
OCTOBER 20, 2000

3. Time of Death

1:30 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

578-38-9503

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 10, 1909

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

☐ Yes 2 ☐ No

10e. Street and Number

6121 MONTROSE RD.

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOSEPH HERZFELD

18. Mother's Name (First, Middle, Maiden Surname)

LENA LONG

19a. Informant's Name/Relationship (Type, Print)

SHERRY Z. SANABRIA daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18163 CANBY RD, LEESBURG, VA 20175

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MIKRO KODESH CEMETERY

Date

10-23-00

20c. Location - City or Town, State

REISTERSTOWN, MD

21. Signature of Funeral Service Licensee

Ronald W. Ruenbush

22. Name and Address of Facility

DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC.

1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ischemic heart disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Probable Alzheimer's dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gary Z. Wilks

29c. License number

D0055258

29d. Date signed (Month, Day, Year)

October 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary B. Wilks Hebrew Home 6121 Montrose Road Rockville Maryland 20852

31. Date filed (Month, Day, Year)

OCT 23 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

b permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35560

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna Elizabeth Zeitler				2. Date of Death Month Day Year October 23 2000		3. Time of Death 8:00am	
	4a. Facility Name (If not institution, give street and number) 4352 Salem Bottom Road				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 216-09-4519		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) July 8 1920	
	9. Birthplace (State or Foreign Country) VA		10a. State Md		10b. County Carroll		10c. City, Town or Location Westminster	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 4352 Salem Bottom Road		10f. Zip Code 21157	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker				16b. Kind of Business/Industry domestic		17. Father's Name (First, Middle, Last) Harrison Samuel Newcomb	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Susie M. Towles				19a. Informant's Name/Relationship (Type, Print) Charles N. Zeitler Sr. (spouse)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4352 Salem Bottom Rd., Westminster, MD 21157	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Pleasant Ridge Cem.		20c. Location - City or Town, State 10-27-2000 Winfield, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Brian A. Haight				22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CORONARY VASCULAR DISEASE YEARS Due to (or as a consequence of): b. HYPERTENSION YEARS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. EMPHYSEMA BREAST CANCER				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Arthur L. Rado, MD ATTENDING PHYSICIAN			
	29c. License number D21155				29d. Date signed (Month, Day, Year) OCT. 24, 2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARTHUR L. RADO, MD 904 WASHINGTON RD WESTMINSTER, MD 21157				31. Date filed (Month, Day, Year) OCT 25 2000			
	32. Registrar's Signature [Signature]				33. State Registrar [Signature]			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35561

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gloria Ann Adams

2. Date of Death

November 3, 2000 6:29 p.m.

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-82-4823

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

37 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 10, 1962

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1813 W. Mosher St.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Afro-American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Candy Co.

17. Father's Name (First, Middle, Last)

Charles Adams

18. Mother's Name (First, Middle, Maiden Surname)

Rose Scott

19a. Informant's Name/Relationship (Type, Print) (mother)

Mrs. Rose Adams

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

827 N. Arlington Ave. Apt. 4 Balto. Md. 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion

Date

11/9/2000

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intra-Cerebral Bleeding

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Robert M. (PCV-1)

29c. License number

89381

29d. Date signed (Month, Day, Year)

11/3/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan Rhodes MD c/o Maryland General Hospital

31. Date filed (Month, Day, Year)

NOV 08 2000

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Gloria Adams
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DONALD ALFORD				2. Date of Death Month Day Year OCTOBER 15, 2000		3. Time of Death 2:50 PM	
	4a. Facility Name (If not institution, give street and number) Prince Georges Hospital Center				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 579-66-7652		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) Jan 17, 1950	
	9. Birthplace (State or Foreign Country) unk		10a. State MD		10b. County Prince Georges		10c. City, Town or Location Temple Hills Upper Marlboro	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 12216 Wimbleton ST 4503 Dallas Place #204		10f. Zip Code 20784 20748		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Vietnam War		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk 12 College (1-4 or 5+) unk 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inspector		16b. Kind of Business/Industry unk u.s. Army				
17. Father's Name (First, Middle, Last) George Alford				18. Mother's Name (First, Middle, Maiden Surname) Hester Jacob				
19a. Informant's Name/Relationship (Type, Print) Dana R. Alford (Daughter) Prince Georges Hospital Center				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4503 Dallas Place #204 Temple Hills Md 20748 3001 Hospital Drive Cheverly, MD 20786				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place) Date		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W, Baltimore Street Baltimore, MD 21201				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. CEREBELLAR HEMORRHAGE Due to (or as a consequence of): b. HYPERTENSION Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier		29c. License number D30318		29d. Date signed (Month, Day, Year) 10/18/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIMITRIOS CATEVENIS 4 DEEPWATER CT, EDGEMONT, MD								
31. Date filed (Month, Day, Year) OCT 23 2000		32. Registrar's Signature B Sparks						

LA 11001 LA 11002

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

B.K.S.

amend item 28a,b,per me G791 1/2/01 yf

State of Maryland / Department of Health and Mental Hygiene

RUTH F. BOWEN

amend item 23a,ptII, 27,28a,b,c,d,ef, per me G790 12/7/00

Certificate of Death

Reg. No.

00 35564

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

State Registrar

Physician / Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Ruth F. Bowen		2. Date of Death Month Day Year NOV. 6, 2000		3. Time of Death 0010 AM	
4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL		4b. City, Town, or Location of Death ESSEX		4c. County of Death BALTIMORE	
5. Social Security Number 217-07-3666	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 7, 1919
9. Birthplace (State or Foreign Country) Maryland		Usual Residence of Decedent			
10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 9107 Deborah Avenue		10f. Zip Code 21236		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical Worker	
16b. Kind of Business/Industry Gas Co.		17. Father's Name (First, Middle, Last) Charles Funk		18. Mother's Name (First, Middle, Maiden Surname) Annabelle Weitzel	
19a. Informant's Name/Relationship (Type, Print) Mrs. Sherry Jacobs (daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5009 Woodbine Road, Woodbine, MD 21797			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. Location - City or Town, State 11/13/00 Baltimore, Maryland	
21. Signature of Funeral Service Licensee Maub T. Z...		22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236			
23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. BILATERAL UPPER EXTREMITY INJURIES Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE; PARKINSON'S DISEASE; ACUTE LOBAR PNEUMONIA		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) found 11/5/00		28b. Time of Injury found unknown 11:45	
28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subjects upper extremities injured by unknown means		28e. Location (Street and Number or Rural Route Number, City or Town, State) Franklin Square Hospital 9000 Franklin Square Drive Rosedale, Maryland	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Y. L. P. M.D.		29c. License number O.C.M.E	
29d. Date signed (Month, Day, Year) NOV. 7, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201			
31. Date filed (Month, Day, Year) NOV 08 2000		32. Registrar's Signature B. Sparks			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35565

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPH LAMONT BRISCO						2. Date of Death Month Day Year Nov 5 2000		3. Time of Death 2010	
	4a. Facility Name (If not Institution, give street and number) Chesapeake Woods Center						4b. City, Town, or Location of Death Cambridge		4c. County of Death Caroline	
Funeral Director	5. Social Security Number 217-44-0803		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 53 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Feb 4, 1947		9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Caroline		10c. City, Town or Location Ridgely	
Usual Residence of Decedent										
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
10e. Street and Number 23592 Henry Road						10f. Zip Code 21660		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) +5						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) policeman			16b. Kind of Business/Industry city police dept	
17. Father's Name (First, Middle, Last) James R. Brisco						18. Mother's Name (First, Middle, Maiden Surname) unk				
19a. Informant's Name/Relationship (Type, Print) Steven R. B. Jones/son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9902 Cerrdae Lane #203 Randallstown, MD 21133				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State
21. Signature of Funeral Service Licensee Ronald S. Wade, Director						22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death)										
a. Esophageal Cancer										
Due to (or as a consequence of):										
b. Hypercalcemia										
Due to (or as a consequence of):										
c.										
Due to (or as a consequence of):										
d.										
Approximate Interval Between Onset and Death										
6 mos										
2 mos										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Michael J. Padden MD						29c. License number 026388		29d. Date signed (Month, Day, Year) Nov 6, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL J. PADDEN 308 COLLINS AVE, HURLOCK, MD										
31. Date filed (Month, Day, Year) NOV 09 2000						32. Registrar's Signature Benjamin S. Sparks				

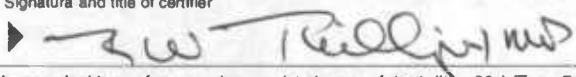
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35566

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Edward Brittain Jr.		2. Date of Death Month: November Day: 9, Year: 2000		3. Time of Death 2:00 a.m.
	4a. Facility Name (If not institution, give street and number) 2555 Ebbvale Road		4b. City, Town, or Location of Death Manchester		4c. County of Death Carroll
Funeral Director	5. Social Security Number 190-14-2685	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.
	8. Date of Birth (Month, Day, Year) Nov. 27, 1924		9. Birthplace (State or Foreign Country) Reading, Pa.		
Usual Residence of Decedent					
10a. State Md.		10b. County Carroll		10c. City, Town or Location Manchester	
10e. Street and Number 2555 Ebbvale Road		10f. Zip Code 21102		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: W.W.II		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 5			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self-employed		16b. Kind of Business/Industry Commercial Refrigeration			
17. Father's Name (First, Middle, Last) Charles Brittain			18. Mother's Name (First, Middle, Maiden Surname) Florence Klink		
19a. Informant's Name/Relationship (Type, Print) Corleen M. Brittain - wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2555 Ebbvale Road Manchester, Md. 21102		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State Nov. 10, 2000 Baltimore, Md.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, Md. 21102			
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Esophageal Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diffuse Metastases					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier 		29c. License number Pa MD014048E		29d. Date signed (Month, Day, Year) Nov 9, 2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) R.W. Phillips / MD 201stock St Hanover Pa 17331					
31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35567

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Brenda Branch				2. Date of Death Month November Day 01 Year 2000		3. Time of Death 10:15 PM	
	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-90-4957		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 35 Yrs.		8. Date of Birth (Month, Day, Year) June 18, 1965	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2626 McElderry St.		10f. Zip Code 21205		10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unemployed		16b. Kind of Business/Industry N/A		17. Father's Name (First, Middle, Last) Alphonso Jennings	
	18. Mother's Name (First, Middle, Maiden Surname) Martha Branch		19a. Informant's Name/Relationship (Type, Print) (Sister) Ms. Linda Branch		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2626 McElderry St. Balto. Md. 21205		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Noshell Mem. Gardens		20c. Location - City or Town, State Dundalk, Md.		21. Signature of Funeral Service Licensee Joseph L. Russ		22. Name and Address of Facility Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Subarachnoid Hemorrhage		Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 12 hours		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 11/7/2000		28b. Time of Injury M	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier John Mulligan, MD		29c. License number D0051750		29d. Date signed (Month, Day, Year) November 01, 2000	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN MULLIGAN, MD 600 N. WOLFE ST Baltimore, Maryland 21287		31. Date filed (Month, Day, Year) NOV 08 2000		32. Registrar's Signature Brenda B. Sparks			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35568

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KATE BOLDING						2. Date of Death Month Day Year NOVEMBER, 04, 2000			3. Time of Death 21:20	
	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL						4b. City, Town, or Location of Death BALTIMORE			4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-60-8565		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Jan. 7, 1917
	9. Birthplace (State or Foreign Country) Virginia										
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 4700 Harford Rd.				10f. Zip Code 21214			10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: African American			
	15. Decedent's Education (Specify only highest grade completed) Elementary Secondary (0-12) 8 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic Worker			16b. Kind of Business/Industry Private Families			
	17. Father's Name (First, Middle, Last) Silas Bolding						18. Mother's Name (First, Middle, Maiden Surname) Addie Cee				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) (daughter) Ms. Marie Skeen						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1519 Argyle Ave. Balto. Md. 21217				
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion		Date 11/13/2000		20c. Location - City or Town, State Lansdowne, Md.		
	21. Signature of Funeral Service Licensee Joseph L. Russ						22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gastro Intestinal Bleeding Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
	Approximate Interval Between Onset and Death 5 days										
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebro vascular Stroke										
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)											
28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Shikhar Soni						29c. License number P-14415		29d. Date signed (Month, Day, Year) November, 04, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHIKHAR SONI, GOOD SAMARITAN HOSPITAL											
31. Date filed (Month, Day, Year) NOV 08 2000		32. Registrar's Signature Benjamin A. Sparks ORIGINAL									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35569

AMEND ITEM: #5 per F.H. G78911-13-00 WR.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Willie Henry Babb		2. Date of Death Month Day Year NOVEMBER 6, 2000		3. Time of Death 7:45 AM
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center		4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 231-22-9115	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) March 4, 1924		9. Birthplace (State or Foreign Country) South Carolina		
Usual Residence of Decedent					
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 110 Judywood Lane		10f. Zip Code 21221		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Construction	
17. Father's Name (First, Middle, Last) Sampie Malcom Babb		18. Mother's Name (First, Middle, Maiden Surname) Elsie Eunice Pittman			
19a. Informant's Name/Relationship (Type, Print) William D. Babb (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17360 RR1 Box 61 B Strickerhouse Rd. Seven Valleys, Pa.			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens Of Faith Cemetery		20c. Location - City or Town, State 11/8/2000 Baltimore, Md.	
21. Signature of Funeral Service Licensee John W. Burkowski		22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death 3 DAYS 3 DAYS			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D19508		29d. Date signed (Month, Day, Year) Nov. 6, 2000	
29b. Signature and title of certifier Natividad D. de Leon, M.D.					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIVIDAD D. DELEON M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204					
31. Date filed (Month, Day, Year) NOV 08 2000		32. Registrar's Signature G. Spence			

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State of Maryland / Department of Health and Mental Hygiene

00 35570

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Melvin W. Boteler				2. Date of Death Month Day Year November 4, 2000				3. Time of Death 1:32 PM		
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 216-03-3010		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) July 7, 1919		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 2 Magnolia Ave.				10f. Zip Code 21061		10g. Citizen of What Country? United States					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII Korean		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Payroll Auditor				16b. Kind of Business/Industry Insurance			
17. Father's Name (First, Middle, Last) Joseph B. Boteler				18. Mother's Name (First, Middle, Maiden Surname) Lessie Dorney							
19a. Informant's Name/Relationship (Type, Print) Melvin B. Boteler/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Magnolia Ave. Glen Burnie, MD 21061							
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Pk.		Nov. 8, 2000		20c. Location - City or Town, State Glen Burnie, MD					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute myocardial infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 				29c. License number D23624		29d. Date signed (Month, Day, Year) November 6, 2000					
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Basant K. Khandelwal 1600 Crain Hwy. Glen Burnie, MD 21061											
31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature 									

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 35571

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward John Chernowski				2. Date of Death Month November Day 8 Year 2000				3. Time of Death 3:45 AM						
	4a. Facility Name (If not institution, give street and number) Keswick Multi Care Center				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A						
Funeral Director	5. Social Security Number 132-03-3622		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) MAY 5, 1920		9. Birthplace (State or Foreign Country) New York						
	Usual Residence of Decedent				10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore						
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 520 Overdale Road				10f. Zip Code 21229		10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1940-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman				16b. Kind of Business/Industry Westinghouse							
17. Father's Name (First, Middle, Last) Joseph Chernowski				18. Mother's Name (First, Middle, Maiden Surname) Anna Blakus											
19a. Informant's Name/Relationship (Type, Print) Alma E. Chernowski/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 Overdale Road Baltimore, MD 21229											
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.				Date 11-8-00		20c. Location - City or Town, State Baltimore, MD					
21. Signature of Funeral Service Licensee Thomas Gregor				22. Name and Address of Facility Cremation Society of MD, Inc.				22. Address of Facility 299 Frederick Road Baltimore, MD 21228							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis and Respiratory arrest Due to (or as a consequence of): b. Dementia Due to (or as a consequence of): c. Cerebrovascular event Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 1 hour years years					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Emphysema										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier Joseph Chernowski		29c. License number D. 223340		29d. Date signed (Month, Day, Year) 11-8-2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Chernowski 700 W 40th Street Balto 21211															
31. Date filed (Month, Day, Year) NOV 08 2000				32. Registrar's Signature B. Spahr											

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35572

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William George Cupp		2. Date of Death Month Day Year November 6, 2000		3. Time of Death 8:00 PM	
	4a. Facility Name (If not institution, give street and number) 214 Stocksdales Avenue		4b. City, Town, or Location of Death Reisterstown		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-32-9562	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 14, 1937
	9. Birthplace (State or Foreign Country) Maryland					
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Maryland		10b. County Baltimore	
	10c. City, Town or Location Cockeysville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 5 Firefly Circle Apt. K		10f. Zip Code 21030		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1954-62		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: White					
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician		16b. Kind of Business/Industry Steel Industry	
	17. Father's Name (First, Middle, Last) William Paul Cupp		18. Mother's Name (First, Middle, Maiden Surname) Gladys Moore			
	19a. Informant's Name/Relationship (Type, Print) Deborah Morrison (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1086 King Road Apt. I112 Malvern, PA 19355			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hepatocellular Carcinoma Due to (or as a consequence of): b. Cirrhosis Due to (or as a consequence of): c. Hepatitis C Due to (or as a consequence of): d. 					Approximate Interval Between Onset and Death 1 Year 1 Year 8 Years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease Diabetes Hypertension					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Sister's Residence			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
State Registrar	29b. Signature and title of certifier 		29c. License number D46342		29d. Date signed (Month, Day, Year) 11/09/2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edgar R. Miller III 2024 E. Monument St. St 2-600 Baltimore, MD 21205					
31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35573

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wesley Joseph Claymore				2. Date of Death Month Day Year Oct 30 2000 1128		3. Time of Death	
	4a. Facility Name (If not institution, give street and number) 7647 Ridge Chapel Rd. Hanover AA				4b. City, Town, or Location of Death		4c. County of Death	
Funeral Director	5. Social Security Number 501-18-1553		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Aug 30, 1921	
	9. Birthplace (State or Foreign Country) ND		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Hanover	
Usual Residence of Decedent				10d. Inside City Limits 1 Yes 2 No				
10a. Street and Number 7647 Ridge Chapel Road				10f. Zip Code 21076		10g. Citizen of What Country? USA		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		
14. Race - American Indian, Black, White, etc. Specify: white				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4 or 5+) unk		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk		
17. Father's Name (First, Middle, Last) unk				18. Mother's Name (First, Middle, Maiden Surname) unk				
19a. Informant's Name/Relationship (Type, Print) unk				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk				
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state				20b. Place of Disposition (Name of cemetery, crematory or other place) unk		20c. Location - City or Town, State unk		
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Arteriosclerotic Heart + Disease UNK Due to (or as a consequence of): b. Chronic Alcoholism UNK Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure Disorder				23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
24a. Was an autopsy performed? 1 Yes 2 No				24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)				
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined				28a. Date of Injury (Month, Day, Year) unk		28b. Time of injury M		
28c. Injury at Work? 1 Yes 2 No				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) unk		
28f. Location (Street and Number or Rural Route Number, City or Town, State) unk								
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier William P. Jones, MD Deputy				
29c. License number DD06054				29d. Date signed (Month, Day, Year) 10/30/00				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) William P. Jones, MD 695 America 21035								
31. Date filed (Month, Day, Year) NOV 09 2000				32. Registrar's Signature Spauls				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

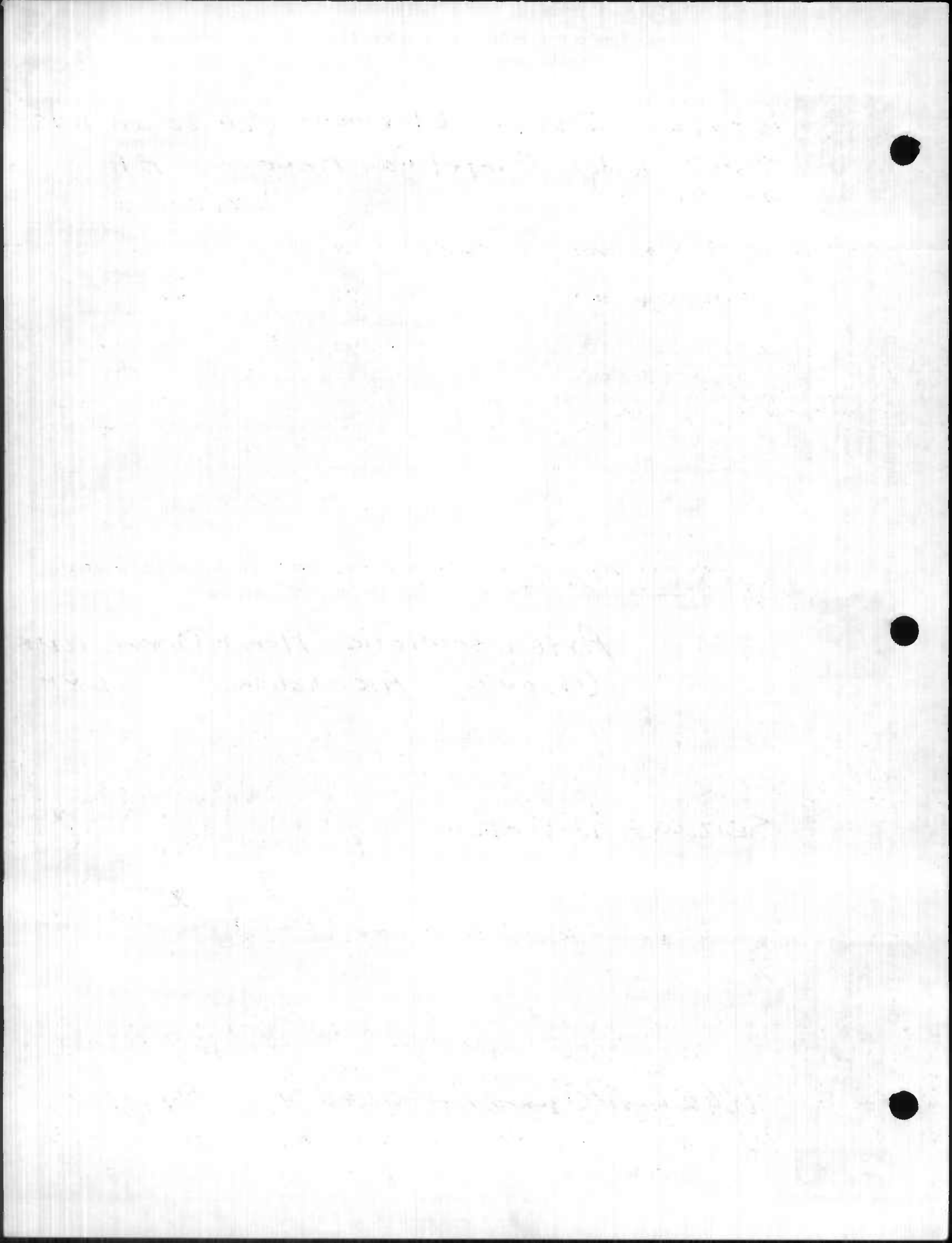
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit notice.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35574

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>CARL CROUSE</u>				2. Date of Death Month <u>NOVEMBER</u> Day <u>7</u> Year <u>2000</u>		3. Time of Death <u>4:30pm</u>	
	4a. Facility Name (If not institution, give street and number) <u>GOOD SAMARITAN HOSPITAL</u>				4b. City, Town, or Location of Death <u>BALTIMORE</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>188-09-5355</u>		6. Sex <u>1</u> M <u>2</u> F	7. Age (In yrs. last birthday) <u>82</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>5/21/18</u>	9. Birthplace (State or Foreign Country) <u>PENNSYLVANIA</u>
	Usual Residence of Decedent							
10a. State <u>MD</u>		10b. County <u>BALTIMORE</u>		10c. City, Town or Location <u>PARKVILLE</u>			10d. Inside City Limits <u>1</u> Yes <u>2</u> No	
10e. Street and Number <u>2327 HARFORD HILLS ROAD</u>				10f. Zip Code <u>21234</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates: <u>WWII</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12TH GRADE</u> College (1-4or 5+) <u>College</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>SALES</u>		16b. Kind of Business/Industry <u>AUTOMOBILE PARTS</u>		
17. Father's Name (First, Middle, Last) <u>MAYNARD CROUSE</u>					18. Mother's Name (First, Middle, Maiden Surname) <u>LILY HOUP</u>			
19a. Informant's Name/Relationship (Type, Print) <u>ROSE S. CROUSE WIFE</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2327 HARFORD HILLS ROAD BALTIMORE, MD 21234</u>				
20a. Method of Disposition <u>1</u> Burial <u>2</u> <input checked="" type="checkbox"/> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>METRO CREMATORY, INC.</u>		Date <u>11/8/00</u>		20c. Location - City or Town, State <u>CATONSVILLE, MD</u>
21. Signature of Funeral Service Licensee <u>Heath N. Hay</u>				22. Name and Address of Facility <u>THE JOHNSON FUNERAL HOME, P.A.</u> <u>8521 LOCH RAVEN BLVD. TOWSON, MD 21286</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. HYPOTENSION</u> Due to (or as a consequence of): <u>b. SEVERE DEHYDRATION</u> Due to (or as a consequence of): <u>c.</u> Due to (or as a consequence of): <u>d.</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DEMENTIA</u>						23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown		
						24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No		24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No
25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No		26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> <input checked="" type="checkbox"/> Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>8</u> Other (Specify)						
27. Manner of Death <u>1</u> Natural <u>5</u> Pending investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <u>1</u> Yes <u>2</u> No		28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <u>1</u> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>Petronella Adomako MD</u>		29c. License number <u>P14416</u>		29d. Date signed (Month, Day, Year) <u>NOVEMBER, 7, 2000</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>PETRONELLA ADOMAKO, GOOD SAMARITAN HOSPITAL, BALTIMORE, MD 21239</u>								
31. Date filed (Month, Day, Year) <u>NOV 09 2000</u>		32. Registrar's Signature <u>[Signature]</u>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35575

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Sarah L. Campbell</i>				2. Date of Death Month <i>11</i> Day <i>07</i> Year <i>2000</i>		3. Time of Death <i>8:25 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Bon Secours Hosp.</i>				4b. City, Town, or Location of Death <i>Baltimore City</i>		4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>212-22-6585</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>72</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Feb. 27, 1928</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>	
	Usual Residence of Decedent							
10a. State <i>Maryland</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <i>3011 W. Lanvale St.</i>				10f. Zip Code <i>21216</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+) <i>0</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Own Home</i>		
17. Father's Name (First, Middle, Last) <i>William Eley</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Evelyn Johnson</i>				
19a. Informant's Name/Relationship (Type, Print) (Husband) <i>Mr. Robert L. Campbell</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3011 W. Lanvale St. Balto. Md. 21216</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Garrison Forest</i>		20c. Location - City or Town, State <i>11/15/2000 Owings Mills, Md.</i>				
21. Signature of Funeral Service Licensee <i>Joseph L. Russ</i>				22. Name and Address of Facility <i>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Hepatic encephalopathy</i> Due to (or as a consequence of): <i>b. Cirrhosis</i> Due to (or as a consequence of): <i>c. Hepatitis C infection</i> Due to (or as a consequence of): <i>d.</i>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Joseph L. Russ MD</i>				29c. License number <i>P 0020040</i>		29d. Date signed (Month, Day, Year) <i>11/7/00</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>J. E. Ham MD, 700 Washington Blvd, Balto, Md 21230</i>								
31. Date filed (Month, Day, Year) <i>NOV 08 2000</i>		32. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

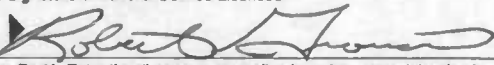

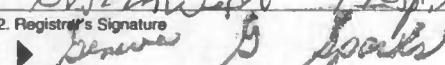
State of Maryland / Department of Health and Mental Hygiene

00 35576

Amended Item 38 per fhg789 11/9/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Leonard Copeland</u>				2. Date of Death Month <u>November</u> Day <u>4</u> Year <u>2000</u>		3. Time of Death <u>9:50 pm</u>		
	4e. Facility Name (If not institution, give street and number) <u>NORTHWEST HOSPITAL CENTER</u>				4b. City, Town, or Location of Death <u>RANDALLSTOWN</u>		4c. County of Death <u>BALTIMORE</u>		
Funeral Director	5. Social Security Number <u>219-01-9659</u>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>81</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>AUG. 14, 1919</u>		
	10a. State <u>MD</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>BALTIMORE</u>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
Usual Residence of Decedent									
10e. Street and Number <u>3601 CLARKS LANE #324</u>				10f. Zip Code <u>21215</u>		10g. Citizen of What Country? <u>U.S.A.</u>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>SALES</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>SALES</u>		16b. Kind of Business/Industry <u>RETAIL</u>			
17. Father's Name (First, Middle, Last) <u>ABRAHAM COPELAND</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>RAYE SACHS</u>					
19e. Informant's Name/Relationship (Type, Print) <u>PHYLLIS COPELAND / WIFE</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3601 CLARKS LANE #324 - BALTIMORE, MD 21215</u>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>HAR SINAI CEMETERY</u>		Date <u>11/7/00</u>		20c. Location - City or Town, State <u>OWINGS MILLS, MD</u>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <u>SOL LEVINSON & BROS., INC.</u> <u>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Pharynx</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number <u>1145974</u>		29d. Date signed (Month, Day, Year) <u>November 4, 2000</u>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Alice Hirsch Northwest Hospital Randallstown, MD</u>									
31. Date filed (Month, Day, Year) <u>NOV 06 2000</u>				32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35577

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mona Wong Chou				2. Date of Death Month Day Year November 4, 2000		3. Time of Death 11:40 AM		
	4a. Facility Name (If not institution, give street and number) Hospice of Baltimore Gilchrist Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 458-47-1785	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 46 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 16, 1954		9. Birthplace (State or Foreign Country) Hong Kong	
	Usual Residence of Decedent								
10e. State MD		10b. County Baltimore		10c. City, Town or Location Pikesville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 3 Hambleton Court				10f. Zip Code 21208		10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Chinese			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Music Teacher		16b. Kind of Business/Industry Private			
17. Father's Name (First, Middle, Last) John NMN Wong				18. Mother's Name (First, Middle, Maiden Surname) Sylvia NMN Hsu					
19e. Informant's Name/Relationship (Type, Print) Dr. Timothy Chou				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Hambleton Court Pikesville, MD 21208					
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Grdns 11/11/00 Timonium, MD		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee Stephen D. Coster MD1122				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cancer of the thymus Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death years		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Helen M. Gordon MD				29c. License number D0051926		29d. Date signed (Month, Day, Year) November 5, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen M. Gordon 6601 N. Charles St Baltimore MD 21204									
31. Date filed (Month, Day, Year) NOV 06 2000		32. Registrar's Signature Helen M. Gordon							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35578

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD DREXEL					2. Date of Death Month 11 Day 4 Year 2000			3. Time of Death 16:06	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND MEDICAL CENTER					4b. City, Town, or Location of Death BALTIMORE			4c. County of Death BALTIMORE CITY	
Funeral Director	5. Social Security Number 212-48-7939		6. Sex XXM 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JULY 18, 1947		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location PASADENA				10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 560 SUNSET KNOLL ROAD				10f. Zip Code 21122		10g. Citizen of What Country? UNITED STATES			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: VIET NAM		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) REPRESENTATIVE				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RETAIL WINDOWS			16b. Kind of Business/Industry RETAIL WINDOWS		
	17. Father's Name (First, Middle, Last) JACK DREXEL					18. Mother's Name (First, Middle, Maiden Surname) DORA BENNETT				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) RICHARD L. DREXEL, JR.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 697 WILLOWBY RUN PASADENA, MD 21122					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		Date NOV. 9, 2000		20c. Location - City or Town, State CATONSVILLE, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. SEPSIS Due to (or as a consequence of): b. MULTIPLE MYELOMA Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number P14688		29d. Date signed (Month, Day, Year) 11/4/2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES LAI MD, UNIVERSITY OF MARYLAND, BALTIMORE MD									
	31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35579

Amend Items 1,24a,25,29a,30per DR,G789,11/09/00dhb

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

~~DAVIS MARY~~

MARY

DAVIS

2. Date of Death

9

29

00

3. Time of Death

8:40 PM

4a. Facility Name (If not institution, give street and number)

MARINEK HEALTH OF SOM

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges

5. Social Security Number

223 24 4996

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Aug 16, 1922

9. Birthplace (State or Foreign Country)

unk

Usual Residence of Decedent

10a. State

MD

10b. County

PR COUNTY

10c. City, Town or Location

CLINTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9211 STUART LN

10f. Zip Code

20735

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

unk

College (1-4 or 5+)

unk

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

childcare

16b. Kind of Business/Industry

unk

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

Mariner Health of Souther MD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9211 Stuart Lane Clinton, MD 20735

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Pneumonia

Due to (or as a consequence of)

Approximate Interval Between Onset and Death

1 hr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Dementia

Due to (or as a consequence of)

2 yr

c.

Coronary Artery Disease

Due to (or as a consequence of)

5 yr

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

LAXMI BERWA, 7700 Old Branch Avenue, Clinton, MD 20735

31. Date filed (Month, Day, Year)

NOV 09 2000

32. Registrar's Signature

Berwa B Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

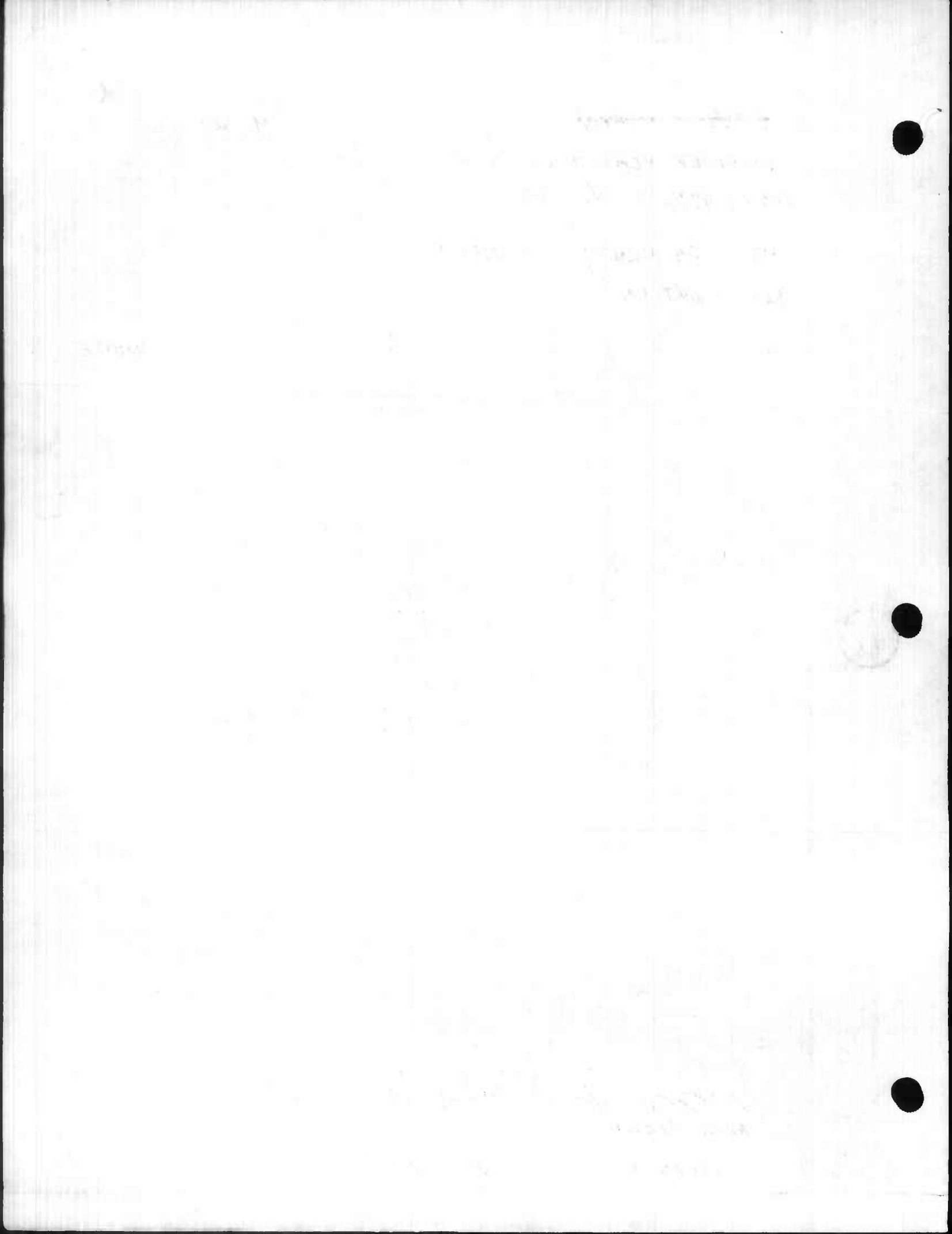
Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

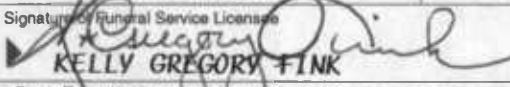


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35580

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HENRY W. DAVISON				2. Date of Death Month Nov Day 5 Year 2000		3. Time of Death 0821	
	4a. Facility Name (If not institution, give street and number) 210-A Hammonds Ferry Road				4b. City, Town, or Location of Death Linthicum		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 212-22-9855		6. Sex 1XX M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) AUG. 13, 1926	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County ANNE ARUNDEL		10c. City, Town or Location LINTHICUM	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 210-A HAMMONDS FERRY ROAD		10f. Zip Code 21090		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TECH WRITER		16b. Kind of Business/Industry WESTINGHOUSE			
	17. Father's Name (First, Middle, Last) CLARENCE DAVISON				18. Mother's Name (First, Middle, Maiden Surname) SALLY LOU DAVIS			
	19a. Informant's Name/Relationship (Type, Print) ETHELYN B. DAVISON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3334-G N. CHATAM RD., ELLICOTT CITY, MD 21042			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		20c. Date 11/6/00		20d. Location - City or Town, State BALTIMORE, MD	
	21. Signature of Funeral Service Licensee  KELLY GREGORY FINK		22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HWY., SW, GLEN BURNIE, MD 21061					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Heart Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  Deputy		29c. License number D06054		29d. Date signed (Month, Day, Year) 11/6/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Jones, MD 695 America 21035								
31. Date filed (Month, Day, Year) NOV 06 2000		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35581

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DEWEY ELROD						2. Date of Death Month Day Year November 3 2000		3. Time of Death 1108 pm	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital center						4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 239-38-3811		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) FEB 27, 1930		9. Birthplace (State or Foreign Country) Tennessee	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 636 Dunwich Way				10f. Zip Code 21221		10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yea or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unemployed/Disabled			16b. Kind of Business/Industry Never Worked			
17. Father's Name (First, Middle, Last) Arthur L. Elrod						18. Mother's Name (First, Middle, Maiden Surname) Janie White				
19a. Informant's Name/Relationship (Type, Print) Brenda Ross/Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 636 Dunwich Way Essex, MD 21221				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		20c. Date 11-8-00		20d. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee Thomas Gregor				22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. End Stage Chronic obstructive lung										
Due to (or as a consequence of): Disease										
Due to (or as a consequence of): Cerebro vascular Accident										
Due to (or as a consequence of): 2 YEARS										
Approximate Interval Between Onset and Death 6 months										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Epilepsy										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier S. A. [Signature]				29c. License number D30641		29d. Date signed (Month, Day, Year) November 7 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD, MD, 821 N. EUTAW STREET - SUITE #308, BALTIMORE, MD 21202										
31. Date filed (Month, Day, Year) NOV 08 2000		32. Registrar's Signature [Signature]								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35582

amend item 23a,27,28a,b,c,d,e,f per me G789 11/10/2000

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SHAWN JACOB ENSMINGER			2. Date of Death Month Day Year NOVEMBER 05, 2000		3. Time of Death 13:15 PM		
	4a. Facility Name (If not institution, give street and number) ST. JOSEPH HOSPITAL			4b. City, Town, or Location of Death Baltimore		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 556-63-3198	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 21 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 12, 1979	9. Birthplace (State or Foreign Country) Ca.	
	Usual Residence of Decedent							
10a. State Md.		10b. County Baltimore		10c. City, Town or Location Lutherville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 506 Spring Ave.			10f. Zip Code 21093		10g. Citizen of What Country? USA			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Server		16b. Kind of Business/Industry Restaurant			
17. Father's Name (First, Middle, Last) William Enslinger			18. Mother's Name (First, Middle, Maiden Surname) Susan Vink					
19a. Informant's Name/Relationship (Type, Print) Mr. Donald M. Vink/grand father			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Spring Ave. Lutherville, Md. 21093					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Park		20c. Location - City or Town, State 11/9/00 Eldersburg, Md.			
21. Signature of Funeral Service Licensed			22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death	
a. NARCOTIC INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 11/5/00		28b. Time of Injury unknown M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred unknown		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home				
		28f. Location (Street and Number or Rural Route Number, City or Town, State) 16 Valley Lake Pl., Cockeysville, Md						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 		29c. License number OCME		29d. Date signed (Month, Day, Year) NOVEMBER 06, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) NOV 06 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35583

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LORETTA H. EHRENBORG				2. Date of Death Month Day Year November 7, 2000		3. Time of Death 11:55 AM	
	4a. Facility Name (If not institution, give street and number) Hospice Of Baltimore, Gilchrist Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 028-03-9811		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 11, 1909	
	9. Birthplace (State or Foreign Country) Ma.		10a. State Md.		10b. County Baltimore		10c. City, Town or Location Towson	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 615 Chestnut Ave.		10f. Zip Code 21204	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Agent				16b. Kind of Business/Industry Insurance		17. Father's Name (First, Middle, Last) John H. Hansen	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Margaret L. Cronin				19. Informant's Name/Relationship (Type, Print) Mrs. Janice Wahlgren/step-daughter			
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1713 Greenspring Dr. Lutherville, Md. 21093				20. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.				20c. Location - City or Town, State Towson, Md.		21. Signature of Funeral Service Licensee	
	22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COLON CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.			
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Hospice				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier M. Daly MD				29c. License number D30433		29d. Date signed (Month, Day, Year) 11/7/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD DALY MD, GBMC 6701 N CHARLES ST BALTIMORE MD 21204				31. Date filed (Month, Day, Year) NOV 9 2000			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature S. B. B. B.				33. State Registrar			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 35584

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles N. Funk, Sr.				2. Date of Death Month November Day 8 Year 2000		3. Time of Death 7:04 AM	
	4a. Facility Name (If not institution, give street and number) Saint Agnes Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
Funeral Director	5. Social Security Number 220-03-0378		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) March 13, 1918	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Baltimore		10c. City, Town or Location Lansdowne Maryland	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 4107 Hollins Ferry Road		10f. Zip Code 21227	
	10g. Citizen of What Country? United States				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Army WWII	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 0	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hairdresser / Cab Driver				16b. Kind of Business/Industry Service / Transportation			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Everett C. Funk				18. Mother's Name (First, Middle, Maiden Surname) Catherine E. Pace			
	19a. Informant's Name/Relationship (Type, Print) Michael J. Funk / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4107 Hollins Ferry Road, Lansdowne Maryland 21227			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Crownsville Veterans Cemetery		20c. Location - City or Town, State Nov. 13, 2000 Crownsville, Maryland	
	21. Signature of Funeral Service Licensee Victor P. Doda, Jr.				22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier Attending Physician	
	29c. License number D51853						29d. Date signed (Month, Day, Year) November 8, 2000	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Silverman, MD 900 Caton Avenue Baltimore 21229						31. Date filed (Month, Day, Year) NOV 09 2000	
	32. Registrar's Signature [Signature]						33. Registrar's Title [Signature]	

ORIGINAL

Stanley Gordon Fisher

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35585

AMEND ITEM: 26 PER MED G789 11-9-00 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Stanley Gordon Fisher			2. Date of Death Month Day Year November 04 2000			3. Time of Death 07:10 A.M.				
	4a. Facility Name (If not institution, give street and number) 1615 Doolittle Road			4b. City, Town, or Location of Death Essex			4c. County of Death Baltimore				
Funeral Director	5. Social Security Number 219-62-0239		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 44 Yrs.		8. Date of Birth (Month, Day, Year) June 15, 1956		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent			10a. State Maryland			10b. County Baltimore			10c. City, Town or Location Essex	
To Be Completed by Funeral Director	10e. Street and Number 91 Stemmers Run Road Apt. E			10f. Zip Code 21221			10g. Citizen of What Country? United States				
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Worker			16b. Kind of Business/Industry Own Business				
	17. Father's Name (First, Middle, Last) Gordon Parker Fisher, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Joyce Eileen Smoot							
To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) George T. Fisher, Sr./Brother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5504 Hamlet Avenue Baltimore, MD 21214							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory, Inc.			20c. Location - City or Town, State Beltsville, MD			20d. Date 11/9/00	
To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee Laura C. Handberg			22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, MD 21286							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
Physician /Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE							
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of injury (Month, Day, Year) 11/4/00 28b. Time of injury (Hour, Minute) 6:59 A M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred SUBJECT STRANGLED 28e. Location (Street and Number or Rural Route Number, City or Town, State) 1615 Doolittle Road ESSEX, MD 28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Parking Lot							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier J. M. Titus							
	29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) November 5, 2000							
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201			31. Data filed (Month, Day, Year) NOV 09 2000							
	32. Registrar's Signature [Signature]			33. [Signature]							

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene 00 35586

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RYAN A. FERNHOLZ				2. Date of Death Month Day Year November 7 2000				3. Time of Death 05:30 A.M.	
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 218-25-0010		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 16 Yrs.		8. Date of Birth (Month, Day, Year) FEB. 19, 1984		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent				10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location MILLERSVILLE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 542 KENORA DRIVE				10f. Zip Code 21108	
	10g. Citizen of What Country? UNITED STATES				11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STUDENT				16b. Kind of Business/Industry EDUCATION				17. Father's Name (First, Middle, Last) CRAIG D. HECK	
	18. Mother's Name (First, Middle, Maiden Surname) JENNIFER L. FERNHOLZ				19a. Informant's Name/Relationship (Type, Print) JENNIFER L. HECK / MOTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 542 KENORA DR., MILLERSVILLE, MARYLAND 21108	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEM. PARK				20c. Location - City or Town, State ELKRIDGE, MARYLAND	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Asthma</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		
29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) November 7, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201		
State Registrar	31. Date filed (Month, Day, Year) NOV 09 2000				32. Registrar's Signature 					

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State of Maryland / Department of Health and Mental Hygiene

00 35587

Amended Item#19b perFHG789 11/9/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CAROLYN RUBENSTEIN FROEHLICH		2. Date of Death Month Day Year November 7, 2000		3. Time of Death 4:00 pm
	4a. Facility Name (If not institution, give street and number) Sinai Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 213-46-3612	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	8. Date of Birth (Month, Day, Year) MAY 26, 1918	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MD	10b. County BALTIMORE	10c. City, Town or Location BALTIMORE		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 6604 CHELWOOD RD.		10f. Zip Code 21209		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		
	17. Father's Name (First, Middle, Last) OSCAR STRAUSS		18. Mother's Name (First, Middle, Maiden Surname) RITA BAER		
	19a. Informant's Name/Relationship (Type, Print) HERBERT FROEHLICH (HUS.)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7218 Park Heights Ave Balto Md 21215 6604 CHELWOOD RD. BALTO., MD 21209		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BNAI ISRAEL		20c. Location - City or Town, State BALTIMORE, MD
	21. Signature of Funeral Service Licensee Robert [Signature]		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Princess Ogbogu, M.D.		29c. License number P14279		29d. Date signed (Month, Day, Year) November 7, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Princess Ogbogu, M.D. - Sinai Hospital, 2401 W. Belvedere, Baltimore MD					
31. Date filed (Month, Day, Year) NOV 06 2000		32. Registrar's Signature [Signature]			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 35588

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna May Grimes				2. Date of Death Month Day Year November 5, 2000				3. Time of Death 10:25am				
	4a. Facility Name (If not institution, give street and number) Harbor Hospital Center				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A				
Funeral Director	5. Social Security Number 213-26-7052		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) Feb. 8, 1932		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent												
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore City						10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10a. Street and Number 1443 Richardson Street				10f. Zip Code 21230				10g. Citizen of What Country? United States					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home					
17. Father's Name (First, Middle, Last) James Welty						18. Mother's Name (First, Middle, Maiden Surname) Minerva Smith							
19a. Informant's Name/Relationship (Type, Print) Gordon K. Grimes, Sr. / Husband						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1443 Richardson Street, Baltimore Maryland 21230							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven cemetery				20c. Location - City or Town, State November 9, 2000 Baltimore Maryland					
21. Signature of Funeral Service Licensee Victor, P. Doda, Jr.				22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute myocardial Infarction b. lung cancer c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 4 years.												Approximate Interval Between Onset and Death hours	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier G. N.						29c. License number D39041			29d. Date signed (Month, Day, Year) November 6, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIATRI NIMMAGADDA 3001 South Baltimore MD 21225 Harmoner Street													
31. Date filed (Month, Day, Year) NOV 09 2000				32. Registrar's Signature James B. Sparks									

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State of Maryland / Department of Health and Mental Hygiene

00 35589

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lenna L. Grubb				2. Date of Death Month Day Year NOVEMBER 5, 2000				3. Time of Death 7:45 AM						
	4a. Facility Name (If not institution, give street and number) Stella Maris @ Mercy Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death n/a						
Funeral Director	5. Social Security Number 234 22-0832	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 8-5-1919		9. Birthplace (State or Foreign Country) West Virginia							
	Usual Residence of Decedent														
10e. State MD		10b. County Baltimore		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number 7407 Alvah Avenue Apt. D				10f. Zip Code 21222		10g. Citizen of What Country? USA									
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry In own home								
17. Father's Name (First, Middle, Last) Leonard Reese McKneely				18. Mother's Name (First, Middle, Maiden Surname) Sina Killen											
19a. Informant's Name/Relationship (Type, Print) husband Clarence E. Grubb				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7407 Alvah Ave. Apt. D Baltimore, Maryland 21222											
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Roselawn Memorial Garden		Date 11/10/00		20c. Location - City or Town, State Princeton, West Virginia							
21. Signature of Funeral Service Licensee Joseph N. Zannino Jr.				22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Hm 263 South Conkling St., Baltimore, Maryland 21224											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Probable Pneumonia Due to (or as a consequence of): b. Congestive Heart Failure Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Renal Failure										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier DAVID RISEBERG		29c. License number D40854		29d. Date signed (Month, Day, Year) NOVEMBER 6, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID RISEBERG 301 ST PAUL PI BALTIMORE, MD 21202															
31. Date filed (Month, Day, Year) NOV 09 2000				32. Registrar's Signature B Sparks											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35590

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Thomas Gill				2. Date of Death Month Day Year November 7, 2000				3. Time of Death 3:45pm	
	4a. Facility Name (If not institution, give street and number) Future Care @ Canton Harbor				4b. City, Town, or Location of Death Baltimore				4c. County of Death n/a	
Funeral Director	5. Social Security Number 217-14-0429		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) 12-18-1919		9. Birthplace (State or Foreign Country) Baltimore, MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore		10c. City, Town or Location Eastpoint				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 7912 Wynbrook Road				10f. Zip Code 21224		10g. Citizen of What Country? USA			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled				16b. Kind of Business/Industry n/a			
	17. Father's Name (First, Middle, Last) Thomas Wolfert Gill				18. Mother's Name (First, Middle, Maiden Surname) Margaret Nichol					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) brother Victor Gill				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8045 Gough St., Baltimore, Maryland 21224					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Memorial		Date 11/10/00		20c. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee Maria B. Zannino				22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Hm 263 South Conkling St. Baltimore, Maryland 21224					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Coronary Arteriosclerotic Heart Disease</i> > 2 yrs Due to (or as a consequence of): b. <i>Atherosclerosis</i> > 2 yrs Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier M. Torres		29c. License number 211150		29d. Date signed (Month, Day, Year) 11/09/2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marta M. Torres, MD 44 S. Ellwood Ave, Baltimore, MD 21224									
	31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature James B. Spaul							

ORIGINAL

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Earle Dixon Gourley, Sr.		2. Date of Death Month Day Year NOVEMBER 6, 2000		3. Time of Death 1430 PM
	4a. Facility Name (If not institution, give street and number) 3304 MAYFAIR ROAD		4b. City, Town, or Location of Death WOODLAWN		4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 213-09-8354	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) July 6, 1918		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10a. State MD		10b. County Baltimore		10c. City, Town or Location Woodmoor	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 3304 Mayfair Road			10f. Zip Code 21207		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security		16b. Kind of Business/Industry NSA	
17. Father's Name (First, Middle, Last) James Stewart Gourley			18. Mother's Name (First, Middle, Maiden Surname) Emma Burns		
19a. Informant's Name/Relationship (Type, Print) Earle Dixon Gourley, Jr. (Son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6520 Riawakin Drive; Salisbury, Maryland 21801		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Wash. Crematory		20c. Location - City or Town, State 11/8/00 Laurel, Maryland	
21. Signature of Funeral Service Licensee Joseph J. Keller M00333		22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? INSPECTION 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) AT SCENE					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier [Signature]		29c. License number OCME		29d. Date signed (Month, Day, Year) NOVEMBER 7, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature [Signature]			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35592

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <i>Tony Gale</i>				2. Date of Death Month <i>November</i> Day <i>3</i> Year <i>2000</i>		3. Time of Death <i>7 AM</i>	
4a. Facility Name (If not institution, give street and number) <i>Gardenview Nursing Home</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>	
5. Social Security Number <i>216-62-8224</i>		6. Sex <i>1</i> M <i>2</i> F	7. Age (In yrs. last birthday) <i>44</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <i>June 6, 1956</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>
Usual Residence of Decedent							
10a. State <i>Maryland</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>		10d. Inside City Limits <i>1</i> Yes <i>2</i> No	
10e. Street and Number <i>615 Roundview Rd.</i>				10f. Zip Code <i>21225</i>		10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <i>1</i> Never Married <i>2</i> Married <i>3</i> Widowed <i>4</i> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <i>1</i> Yes <i>2</i> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1</i> Yes <i>2</i> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Tailor</i>		16b. Kind of Business/Industry <i>Private Firm</i>	
17. Father's Name (First, Middle, Last) <i>Genesis Gale</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Connie M. Byrd</i>			
19a. Informant's Name/Relationship (Type, Print) (Wife) <i>Mrs. Mavis L. Gale</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4169 Labyrinth Rd. Balto. Md. 21215</i>			
20a. Method of Disposition <i>1</i> Burial <i>2</i> Cremation <i>3</i> Removal from State <i>4</i> Donation <i>5</i> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Zion</i>		Date <i>11/9/2000</i>		20c. Location - City or Town, State <i>Lansdowne, Md.</i>	
21. Signature of Funeral Service Licensee <i>Joseph L. Russ</i>				22. Name and Address of Facility <i>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)		a. <i>Anoxic Encephalopathy</i> Due to (or as a consequence of):				Approximate Interval Between Onset and Death <i>1 Year</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <i>Cerebrovascular accident</i> Due to (or as a consequence of):				<i>1 Month</i>	
		c. _____ Due to (or as a consequence of):					
		d. _____ Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <i>1</i> Yes <i>2</i> No <i>3</i> Probably <i>4</i> Unknown							
24a. Was an autopsy performed? <i>1</i> Yes <i>2</i> No						24b. Were autopsy findings available prior to completion of cause of death? <i>1</i> Yes <i>2</i> No	
25. Was case referred to medical examiner? <i>1</i> Yes <i>2</i> No		26. Place of Death (Check only one) Hospital: <i>1</i> Inpatient <i>2</i> ER/Outpatient <i>3</i> DOA Other: <i>4</i> Nursing Home <i>5</i> Residence <i>6</i> Other (Specify)					
27. Manner of Death <i>1</i> Natural <i>5</i> Pending investigation <i>2</i> Accident <i>6</i> Could not be determined <i>3</i> Suicide <i>4</i> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <i>1</i> Yes <i>2</i> No	
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <i>1</i> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>2</i> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>D. M. - O. K. Durr, MD</i>				29c. License number <i>031865</i>		29d. Date signed (Month, Day, Year) <i>11-3-00</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Rm 206 821 N. Guntan street Baltimore md 21201</i>							
31. Date filed (Month, Day, Year) <i>NOV 08 2000</i>				32. Registrar's Signature <i>Bernard B. Sparks</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35593

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LINDA L GROVE				2. Date of Death Month November Day 5 Year 2000		3. Time of Death 6:00 AM	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 475-46-6381	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 22, 1941		9. Birthplace (State or Foreign Country) Minnesota
	Usual Residence of Decedent							
10a. State MD		10b. County Baltimore		10c. City, Town or Location Middle River			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 10031 Icabod Lane				10f. Zip Code 21220		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Software Quality Engineer			16b. Kind of Business/Industry Lockheed-Martin	
17. Father's Name (First, Middle, Last) Krier				18. Mother's Name (First, Middle, Maiden Surname) Lois Worden				
19a. Informant's Name/Relationship (Type, Print) Ronald R. Grove / husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10031 Icabod Lane Baltimore Md. 21220				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Cemetery		Date 11/9/2000		20c. Location - City or Town, State Baltimore Md.		
21. Signature of Funeral Service Licensee R. Terry Connelly				22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD 21221				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Intracranial Bleed								Approximate Interval Between Onset and Death 6 hours
Immediate Cause (Final disease or condition resulting in death) Intracranial Bleed								
Due to (or as a consequence of):								
Due to (or as a consequence of):								
Due to (or as a consequence of):								
Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier M. Chardon, MD				29c. License number 192658		29d. Date signed (Month, Day, Year) November 5 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Madaï Chardan MD 9000 Franklin Square Drive Baltimore Maryland 21237								
31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature [Signature]						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 29d per Dr, G789, 11/09/00dhhb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35594

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VALENTINA GRINSHUPUN		2. Date of Death Month Day Year OCTOBER 27, 2000		3. Time of Death 10:00 AM
	4a. Facility Name (If not institution, give street and number) 6940 BROOKMILL ROAD, APT. 1-A		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 214-35-9247	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) DEC 10 1926		9. Birthplace (State or Foreign Country) UKRAINE		
Usual Residence of Decedent					
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 6940 BROOKMILL ROAD, APT. 1-A			10f. Zip Code 21215		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BOOKKEEPER	
16b. Kind of Business/Industry JEWELRY		17. Father's Name (First, Middle, Last) ISRAEL PLISETSKY		18. Mother's Name (First, Middle, Maiden Surname) FRUMA GERLEANTS	
19a. Informant's Name/Relationship (Type, Print) ALEKSANDER GRINSHUPUN/HUSBAND			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6940 BROOKMILL ROAD APT. 1-A BALTIMORE, MD. 21215		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematorium, or other place) HAR SINAI CONGREGATION		20c. Location - City or Town, State 10/29/00 OWINGS MILLS, MD.	
21. Signature of Funeral Service Licensee Scott M. Cutler		22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Breast Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Dr. J. Fung		29c. License number 018320		29d. Date signed (Month, Day, Year) October 27, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Fetting MD Johns Hopkins Oncology 10753 Falls Rd. Lutherville MD 21093					
31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature Anna B. Sparks			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 35595

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Carter Hicklin, Sr.				2. Date of Death Month November Day 4 Year 2000		3. Time of Death 2:40AM	
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA	
Funeral Director	5. Social Security Number 249-44-8528		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) 12-10-28	
	9. Birthplace (State or Foreign Country) SC		10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
Usual Residence of Decedent								
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
10e. Street and Number 1437 Carswell Street				10f. Zip Code 21218		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shipping Clerk			16b. Kind of Business/Industry Westinghouse Co.	
17. Father's Name (First, Middle, Last) James Hicklin				18. Mother's Name (First, Middle, Maiden Surname) Pernia Hicklin				
19a. Informant's Name/Relationship (Type, Print) Mary F. Hicklin				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1437 Carswell Street Baltimore, Maryland 21218				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) King Mem. Pk. Cem. 11-10-2000 Randallstown, MD		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee Gladys Wane				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)								
a. ACUTE PULMONARY EMBOLISM								
Due to (or as a consequence of):								
b. DEEP VEIN THROMBOSIS								
Due to (or as a consequence of):								
c. PROSTATE CANCER								
Due to (or as a consequence of):								
d.								
Approximate Interval Between Onset and Death								
30 MINUTES								
2 DAYS								
4 1/2 YEARS								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day, Year)								
28b. Time of Injury M								
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Raymond Taylor MD								
29c. License number D37370								
29d. Date signed (Month, Day, Year) NOVEMBER 4, 2000								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAYMOND TAYLOR UNION MEMORIAL HOSPITAL								
31. Date filed (Month, Day, Year) NOV 09 2000								
32. Registrar's Signature James B Sparks								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35596

Amend Item 5 per FH, G790, 12/11/00dhb

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RAPHAEL HAMILTON

2. Date of Death

Month
NovDay
4Year
2000

3. Time of Death

4 AM

4a. Facility Name (If not institution, give street and number)

Lorien Frankford Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral
Director

5. Social Security Number

080-66-5779

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

06-01-29

9. Birthplace (State or Foreign Country)

Jamaica

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

X□Yes 2□No

10e. Street and Number

4511 Frankford Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1□Never Married 2□Married
3□Widowed 4□Divorced12. Was Decedent Ever in U.S.
Armed Forces?1□Yes XXNo
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□Yes 2XNo Specify:

14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

2yrs.

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Nursing Assistant

16b. Kind of Business/Industry

Jacobi Hospital

17. Father's Name (First, Middle, Last)

Hugh George

18. Mother's Name (First, Middle, Maiden Surname)

Annell Fergusson

19a. Informant's Name/Relationship (Type, Print)

Ceceline + Denroy Hamilton

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4511 Frankford Avenue Baltimore, Maryland 21206

20a. Method of Disposition

1□Burial 2XCremeration 3□Removal from State
4□Donation 5□Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Greenmount Cemetery 11-11-2000 Baltimore, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202
WM.C. March FH 1101 E. North Avenue23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cerebrovascular Accident

Dua to (or as a consequence of):

Approximate
Interval Between
Onset and Death

WKS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Dua to (or as a consequence of):

c. Dua to (or as a consequence of):

d. Dua to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pneumonia

23b. Did tobacco use contribute to the cause of death?

1□Yes 2□No 3XProbably 4□Unknown

24a. Was an autopsy
performed?

1□Yes 2XNo

24b. Were autopsy findings
available prior to
completion of cause
of death?

1□Yes 2XNo

25. Was case referred to medical
examiner?

1□Yes 2XNo

26. Place of Death (Check only one)

Hospital: 1□Inpatient 2□ER/Outpatient 3□DOA

Other: 4XNursing Home 5□Residence 6□Other (Specify)

27. Manner of Death

1XNatural 5□Pending
investigation
2□Accident 6□Could not be
determined
3□Suicide
4□Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?

1□Yes 2□No

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Matthew McNally MD

29c. License number

DYS757

29d. Date signed (Month, Day, Year)

Nov 6, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew McNally MD 5505 (Topic) Bayview Circle Baltimore MD 21224

State
Registrar

31. Date filed (Month, Day, Year)

NOV 09 2000

32. Registrar's Signature

Benjamin Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35597

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <i>Perry Hall</i>		2. Date of Death Month <i>November</i> Day <i>7</i> Year <i>2000</i>		3. Time of Death <i>1:45 pm</i>	
4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical Systems</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>NIA</i>	
5. Social Security Number <i>213-36-4409</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>60</i> Yrs.	
8. Date of Birth Month <i>JAN</i> Day <i>30</i> Year <i>1940</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>			
Usual Residence of Decedent					
10a. State <i>MD</i>		10b. County <i>NIA</i>		10c. City, Town or Location <i>Baltimore</i>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <i>1730 N. Dallas St.</i>		10f. Zip Code <i>21213</i>		10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10th</i> College (1-4or 5+) <i>Custodian</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Custodian</i>		16b. Kind of Business/Industry <i>Dept. Store</i>	
17. Father's Name (First, Middle, Last) <i>Irvin L. Hall</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Edna Cook</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Doris L. Johnson - sister</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1032 N. Patterson PARK BALTO, MD. 21205</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>mt. Calvary Cemetery</i>		20c. Date <i>11-10-00</i>	
20d. Location - City or Town, State <i>Glen Burnie, MD.</i>					
21. Signature of Funeral Service Licensee <i>Samuel P. March</i>		22. Name and Address of Facility <i>Samuel P. March Funeral Home P.A. 240 Fredhillen Ross BALTO, MD. 21229</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. <i>Myocardial infarction</i>					
Due to (or as a consequence of):					
b. <i>Cardiac Arrest</i>					
Due to (or as a consequence of):					
c. _____					
Due to (or as a consequence of):					
d. _____					
Approximate Interval Between Onset and Death <i>45 minutes</i> <i>45 minutes</i>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and manner stated.					
29b. Signature and title of certifier <i>Sunita Koshy MD</i>		29c. License number <i>13127</i>		29d. Date signed (Month, Day, Year) <i>November 8, 2000</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Sunita Koshy, MD 22 South Greene St., Baltimore, Maryland 21201</i>					
31. Date filed (Month, Day, Year) <i>NOV 09 2000</i>		32. Registrar's Signature <i>Benny B. Sparks</i>			

ORIGINAL


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35598

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Loretta Agnes Hannon				2. Date of Death Month Day Year November 7, 2000		3. Time of Death 0110	
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-16-5100	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 12, 1912		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 2622 Miles Avenue				10f. Zip Code 21211		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telegraph Operator		16b. Kind of Business/Industry Western Union			
	17. Father's Name (First, Middle, Last) Thomas Wehn				18. Mother's Name (First, Middle, Maiden Surname) Carrie Butcher Ebaugh			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Victoria H. Powell Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9727 Harford Road Baltimore, MD 21211			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore National		Date 11/09/00		20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Emphysema Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death 2 days 16 years 6 years							
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Vicki Hubbard, MD				29c. License number AU417635H13184		29d. Date signed (Month, Day, Year) November 7, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vicki Hubbard, MD 201 E. University Pkwy., Baltimore, MD 21218								
31. Date filed (Month, Day, Year) NOV 09 2000				32. Registrar's Signature 				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35599

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Debra Harvey				2. Date of Death Month October Day 25 Year 2000				3. Time of Death 11:29am	
	4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center				4b. City, Town, or Location of Death Baltimore				4c. County of Death	
Funeral Director	5. Social Security Number 216-74-4656		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 44 Yrs.		8. Date of Birth (Month, Day, Year) JUNE, 4, 1956		9. Birthplace (State or Foreign Country) MD.	
	10a. State MD.		10b. County BALTO		10c. City, Town or Location		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 4145 FAIRFAX RD.				10f. Zip Code		10g. Citizen of What Country? USA.			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) disable				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry	
	17. Father's Name (First, Middle, Last) JOHN HARVEY				18. Mother's Name (First, Middle, Maiden Surname) JENNETTE WILLIAMS					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) PAMELA HARVEY				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3101 TOWANDA AVE BALTO 21225					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Gardens 2000 BALTO MD		20c. Location - City or Town, State			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Wesley Chan				22. Name and Address of Facility CHAVIS F.H. 2007 EASTERN BALTO 21231					
	23a. Permit: Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Thyroid Storm				Approximate Interval Between Onset and Death 2 weeks					
To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Cerebral Edema Hepatic Failure				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Barry J. Mark MD				29c. License number P 14678	
To Be Completed by Physician/Medical Examiner	29d. Data signed (Month, Day, Year) October 25, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry J. Mark 22 S. Greene St., Baltimore, MD 21230					
	31. Date filed (Month, Day, Year) NOV 08 2000				32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35600

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MILBURN J. HENSON, Jr.				2. Date of Death Month Day Year 10 30 2000		3. Time of Death 8 A.M.	
	4a. Facility Name (If not institution, give street and number) BON SECOURS Hosp.				4b. City, Town, or Location of Death BALTO		4c. County of Death N.A.	
Funeral Director	5. Social Security Number 212 42 7496	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 4-6-46		9. Birthplace (State or Foreign Country) Md.
	Usual Residence of Decedent							
10a. State Md.		10b. County N.A.		10c. City, Town or Location BALTO			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 812 N. MONROE ST				10f. Zip Code 21217		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 5/74 6/17		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry FEDERAL GOVT.		
17. Father's Name (First, Middle, Last) MILBURN J. HENSON Sr.				18. Mother's Name (First, Middle, Maiden Surname) MILDRED RAY				
19a. Informant's Name/Relationship (Type, Print) DOLORES DAVENPORT				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1807 CHELSEA RD BALTO MD 21217				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST		20c. Date 11/6/00		20d. Location - City or Town, State OWINGS MILLS MD		
21. Signature of Funeral Service Licensee Joseph M. Locke Jr.				22. Name and Address of Facility Joseph M. Locke Jr. 9/4 1304 N Central				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Hepatic Failure Due to (or as a consequence of): b. Cerebral edema Due to (or as a consequence of): c. Chronic Alcoholism Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Amil UBEROL MD				29c. License number D26748		29d. Date signed (Month, Day, Year) 11/2/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIL UBEROL MD 4419 FALLS RD BALTO MD 21211								
31. Date filed (Month, Day, Year) NOV 08 2000				32. Registrar's Signature Benjamin A. Sparks				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ERNA
HINDS

amend item 1,23a,27 per me G789 11/13/00 yf

State of Maryland / Department of Health and Mental Hygiene

00 35601

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna Hinds Erna Hinds Dukes		2. Date of Death Month Day Year OCTOBER 19, 2000		3. Time of Death 11:08P.M.
	4a. Facility Name (If not institution, give street and number) 5110 NELSON AVE		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 163-48-5307	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Aug. 21, 1936		9. Birthplace (State or Foreign Country) Germany		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MD	10b. County Baltimore	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 5110 Nelson Avenue		10f. Zip Code 21215		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Ernst Spiehs			18. Mother's Name (First, Middle, Maiden Surname) Franziska Breuer		
19a. Informant's Name/Relationship (Type, Print) Albert Dukes / Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5115 Nelson Avenue, Baltimore MD 21215		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Jacobstown cemetery		20c. Location - City or Town, State October 25, 2000 Jacobstown, NJ	
21. Signature of Funeral Service Licensee Victor P. Doda, Jr.			22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIAC HYPERTROPHY WITH LEFT VENTRICULAR DILATATION AND FOCAL MODERATE ATHEROSCLEROSIS				Approximate Interval Between Onset and Death
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier Joseph Pestaner, M.D.		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) OCTOBER 20, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35602

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Colonel Hall</i>				2. Date of Death Month <i>November</i> Day <i>1</i> Year <i>2000</i>				3. Time of Death <i>3:15 A</i>			
	4a. Facility Name (If not institution, give street and number) <i>Levindale Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore MD</i>				4c. County of Death <i>City</i>			
Funeral Director	5. Social Security Number <i>217-30-3441</i>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>64</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>3-19-1936</i>		9. Birthplace (State or Foreign Country) <i>MD.</i>			
	Usual Residence of Decedent											
10a. State <i>MD.</i>		10b. County <i>MD.</i>		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
10e. Street and Number <i>4724 Wrenwood Ave</i>				10f. Zip Code <i>21212</i>		10g. Citizen of What Country? <i>U.S.A.</i>						
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <i>June 1963</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>N/A</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>LABORER</i>				16b. Kind of Business/Industry <i>BETH STEEL</i>				
17. Father's Name (First, Middle, Last) <i>Colonel A. Hall Sr.</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Anita Boyd</i>						
19a. Informant's Name/Relationship (Type, Print) <i>Viola Hall (wife)</i>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4724 Wrenwood Ave. Balto. MD. 21213</i>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>CARRISON FOREST VA</i>		20c. Location - City or Town, State <i>11/8/2000 Owings Mills Md.</i>						
21. Signature of Funeral Service Licensee <i>James J. Corrao</i>				22. Name and Address of Facility <i>BETHS FUNERAL HOME 1129 N. Caroline St. Balto. MD. 21213</i>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Cerebrovascular Accident</i> Due to (or as a consequence of): <i>b. Hypertension</i> Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>c.</i> Due to (or as a consequence of): <i>d.</i> Due to (or as a consequence of):											Approximate Interval Between Onset and Death <i>Sept. 2000</i> <i>years</i>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
											24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
											24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, a/c. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. Signature and title of certifier <i>Debra S. Wertheimer MD</i>				29c. License number <i>D23767</i>				29d. Date signed (Month, Day, Year) <i>November 1, 2000</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Debra S. Wertheimer MD, 2434 W. Belvedere Ave, Balto, MD 21215</i>												
31. Date filed (Month, Day, Year) <i>NOV 09 2000</i>				32. Registrar's Signature <i>Benjamin B. Sparks</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1/2 3 4 5 6 7 8 9 10 11 12

1/2 3 4 5 6 7 8 9 10 11 12

1/2 3 4 5 6 7 8 9 10 11 12

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1/2 3 4 5 6 7 8 9 10 11 12

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35603

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Howard Harris				2. Date of Death Month Day Year October 31 2000				3. Time of Death 8:30 PM	
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death 7/a	
Funeral Director	5. Social Security Number 217245818		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) 2-25-1933		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State md		10b. County 7/a		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10a. Street and Number 3573 Shannon Dr.				10f. Zip Code 21213		10g. Citizen of What Country? U.S.A			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) 7/a		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry Costal Moduler Corp					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) George Parker				18. Mother's Name (First, Middle, Maiden Surname) Gladys Harris					
	19a. Informant's Name/Relationship (Type, Print) Donita Steward (Niece)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3573 Shannon Dr. Balt. Md. 21213					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Va.		Date 11/9/2000		20c. Location - City or Town, State Owings Mills MD.			
	21. Signature of Funeral Service Licensee James L. Crommette				22. Name and Address of Facility Beths Funeral Home 1129 N. Caroline Balt. Md. 21213					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebral vascular accident Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Amyloidosis Due to (or as a consequence of): d. Poly myositis								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28i. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier Linda Lindsey MD				29c. License number P13 454		29d. Date signed (Month, Day, Year) October 31 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Blvd. Baltimore Md. 21239									
State Registrar	31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature Benjamin S. Sparks							

ORIGINAL

Baltimore, Maryland 21215-0036

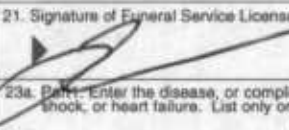
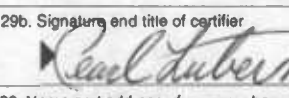
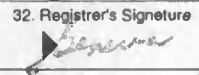
Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene 00 35604

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Helen Holland</u>				2. Date of Death Month Day Year <u>November 8 2000</u>		3. Time of Death <u>2:20 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Good Samaritan Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>220-32-3229</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <u>87</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>9/24/13</u>	9. Birthplace (State or Foreign Country) <u>MARYLAND</u>
	Usual Residence of Decedent							
10a. State <u>MD</u>		10b. County <u>BALTIMORE</u>		10c. City, Town or Location <u>LOCH RAVEN HEIGHTS</u>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <u>1903 WILDWOOD AVENUE</u>				10f. Zip Code <u>21234</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6TH GRADE</u> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>PRESSER</u>			16b. Kind of Business/Industry <u>DRY CLEANING</u>	
17. Father's Name (First, Middle, Last) <u>EARL BEARES</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>ELISE GREEN</u>				
19a. Informant's Name/Relationship (Type, Print) <u>FRED HOLLAND SON</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1903 WILDWOOD AVENUE BALTIMORE, MD 21234</u>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>DULANEY VALLEY MEM. GAR.</u>		20c. Location - City or Town, State <u>11/10/00 COCKEYSVILLE, MD</u>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <u>THE JOHNSON FUNERAL HOME, P.A.</u> <u>8521 LOCH RAVEN BLVD. TOWSON, MD 21286</u>				
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. Ventilatory Insufficiency</u> Due to (or as a consequence of): <u>b. Congestive heart failure</u> Due to (or as a consequence of): <u>c. Cor Pulmonale</u> Due to (or as a consequence of): <u>d. Chronic Obstructive Pulmonary Disease</u>				Approximate Interval Between Onset and Death <u>3 days</u> <u>~2 years</u> <u>years</u>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hyperthyroidism</u> <u>Coronary Artery Disease</u>						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred				28e. Place of Injury - At home, term, street, lecture, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number <u>D0055998</u>		29d. Date signed (Month, Day, Year) <u>November 8, 2000</u>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Pearl Laber mn Good Samaritan Hospital</u>								
31. Date filed (Month, Day, Year) <u>NOV 09 2000</u>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35605

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CATHERINE E. HOFMANN				2. Date of Death Month Day Year NOV. 5 2000		3. Time of Death 10:15 A.M.												
	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE												
Funeral Director	5. Social Security Number 129-05-3409	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 3/29/16		9. Birthplace (State or Foreign Country) NEW YORK											
	Usual Residence of Decedent																		
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location HILLENDALE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
10e. Street and Number 8110 DALESFORD ROAD				10f. Zip Code 21234		10g. Citizen of What Country? USA													
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE												
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME												
17. Father's Name (First, Middle, Last) LOUIS STURM				18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH VELTON															
19a. Informant's Name/Relationship (Type, Print) HENRY O. HOFMANN SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1906 LAUREL BROOK RD. FALLSTON, MD 21047															
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MORELAND MEMORIAL PARK		20c. Location - City or Town, State 11/9/00 HILLENDALE, MD													
21. Signature of Funeral Service Licensee				22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286															
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Pneumonia</td> <td rowspan="4"> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): </td> <td rowspan="4"> Approximate Interval Between Onset and Death </td> </tr> <tr> <td>b.</td> <td>Emphysema</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Pneumonia	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b.	Emphysema	c.		d.	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Pneumonia	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death															
	b.	Emphysema																	
	c.																		
	d.																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown													
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred											
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier Hassan Mokkzoum M.D.				29c. License number D22530		29d. Date signed (Month, Day, Year) 11/6/00													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hassan Mokkzoum M.D. 120 Sixth Avenue Dr. Towson																			
State Registrar		31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature [Signature]															

ORIGINAL


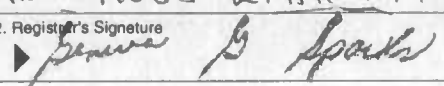
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35606

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kenneth E Haynie				2. Date of Death Month Nov Day 7 Year 2000		3. Time of Death 4:30 AM		
	4a. Facility Name (If not institution, give street and number) Howard County General Hospital				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard		
Funeral Director	5. Social Security Number 221-24-5207		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) Jan 14, 1939		
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Howard		10c. City, Town or Location Ellicott City		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 3500 Dairy Valley Trail		10f. Zip Code 21042		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Specialist		16b. Kind of Business/Industry Government		17. Father's Name (First, Middle, Last) William Haynie		18. Mother's Name (First, Middle, Maiden Surname) Anne Givens	
19a. Informant's Name/Relationship (Type, Print) Mrs. Susanne E. Haynie		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3500 Dairy Valley Trail Ellicott City, Maryland 21042		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation Services, Inc.		20c. Location - City or Town, State Sykesville, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Hemorrhagic shock Due to (or as a consequence of): c. Melanoma metastatic to bone, brain, GI tract, peritoneum Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 1 day 7 days 6 months			
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D 30573		29d. Date signed (Month, Day, Year) 11-7-00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jon M. Sparks MD 11065 Little Patuxent Parkway Columbia MD	
31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature 		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35607

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kathleen Greeley Harrington				2. Date of Death Month Day Year November 5, 2000		3. Time of Death 1:25 AM	
	4a. Facility Name (If not institution, give street and number) Oakcrest Care Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 012-28-7805		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) 12-14-1908	
	9. Birthplace (State or Foreign Country) Mass.		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
Usual Residence of Decedent								
10a. State Maryland			10b. County Baltimore			10c. City, Town or Location Baltimore		
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			10e. Street and Number 8800 Walther Blvd.			10f. Zip Code 21234		
10g. Citizen of What Country? U. S. A.			11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Proof Reader			16b. Kind of Business/Industry Courier Citizen Co.			17. Father's Name (First, Middle, Last) John Greeley		
18. Mother's Name (First, Middle, Maiden Surname) Mary Ellen Judge			19a. Informant's Name/Relationship (Type, Print) Mrs Kathleen H. Manchester (DTR.)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Marsh Point Circle, St. Augustine, Fl. 32084		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) St. Patrick, S Cemetery			20c. Location - City or Town, State Lowell, Mass.		
21. Signature of Funeral Service Licensee Wallace S. Brooks Jr.			22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204			23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE FEBRILE ILLNESS Due to (or as a consequence of): ENDSTAGE DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PARKINSONISM HYPERTENSION		
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day Year)			28b. Time of Injury M			28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred			28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier Kendall R. Faulkner			29c. License number D25643		
29d. Date signed (Month, Day, Year) 11/06/2000			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K R Faulkner MD / 8800 Walther Blvd / Baltimore, MD 21234			31. Date filed (Month, Day, Year) NOV 06 2000		
32. Registrar's Signature [Signature]			33. State Registrar			34. State Registrar		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35608

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harry John Himmel

2. Date of Death

Month

Day

Year

November

5

2000

3. Time of Death

9:35 PM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

218 16 6550

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

August 2, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Linthicum

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

22 Mansion Road

10f. Zip Code

21090

10g. Citizen of What Country?

U.S.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates: W.W. II

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Letter Carrier

16b. Kind of Business/Industry

U.S. Post Office

17. Father's Name (First, Middle, Last)

George Himmel

18. Mother's Name (First, Middle, Maiden Surname)

Ella Kirby

19a. Informant's Name/Relationship (Type, Print)

Ann Himmel / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22 Mansion Road Linthicum, Maryland 21090

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cedar Hill Cemetery

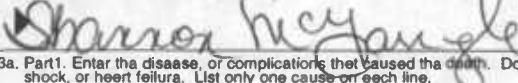
Date

11/9/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Amyotrophic lateral sclerosis

Due to (or as a consequence of):

months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

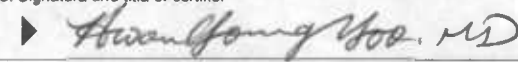
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D0053514

29d. Date signed (Month, Day, Year)

November 5 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hwan Y. Yoo, MD, St. Agnes Hospital, Baltimore, MD 21229

31. Date filed (Month, Day, Year)

NOV 09 2000

32. Registrar's Signature



State Registrar

Himmel, Harry
Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

NAME

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitpermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35609

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MaryLou Hartman				2. Date of Death Month November Day 6, Year 2000		3. Time of Death 3:30 AM		
	4a. Facility Name (If not institution, give street and number) 3909 Ridgcroft Road				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 219-38-3213	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 08/10/1942		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 3909 Ridgcroft Road			10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Admissions Clerk			16b. Kind of Business/Industry Hospital			
	17. Father's Name (First, Middle, Last) Kenneth Marlin Benner				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Elizabeth Eisenhauer				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Joseph Hartman			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3909 Ridgcroft Road Baltimore, Maryland 21206					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Balto.?Wash. Crematory		Date 11/9/00		20c. Location - City or Town, State Laurel, Maryland		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>RENAL FAILURE</u> Due to (or as a consequence of): b. <u>INSULIN DEPENDENT DIABETES MELLITUS</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 2 YRS. YEARS	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CORONARY ARTERY DISEASE</u> <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 			29c. License number D15135		29d. Date signed (Month, Day, Year) NOVEMBER 6, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PENELOPE A. SCOTT MD 5601 LOCH MARSH BLVD BALTIMORE, MD 21239									
31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature 							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35610

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alonza W. Jackson				2. Date of Death Month Day Year NOV. 5, 2000		3. Time of Death 10:53 AM		
	4a. Facility Name (If not institution, give street and number) 1602 VINCENT COURT APT.#5				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA		
Funeral Director	5. Social Security Number 220-50-4356	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 06-23-46		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County NA	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 1602 Vincent Court Apt.#5			10f. Zip Code 21217		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade College (1-4 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Delivery			16b. Kind of Business/Industry Food Company			
	17. Father's Name (First, Middle, Last) Alonza W. Jackson				18. Mother's Name (First, Middle, Maiden Surname) Catherine Quice				
	19a. Informant's Name/Relationship (Type, Print) Catherine Jackson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD. 1010 W. Baltimore Street Apt.#213 Baltimore				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery		Date 11-09-2000		20c. Location - City or Town, State Baltimore, MD		
	21. Signature of Funeral Service Licensee Bladys W. W. W.				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gastrointestinal hemorrhage Due to (or as a consequence of): b. Gastroesophageal mucosal tears Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alcoholism						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Stephen S. Radentz				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) NOV. 6, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201									
State Registrar	31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature Benjamin B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35611

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPH JOHN JEDROWICZ, SR.				2. Date of Death Month Day Year NOVEMBER 3, 2000				3. Time of Death 6:55 AM	
	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				4b. City, Town, or Location of Death ANNAPOLIS				4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 219-18-7856		6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) FEB. 20, 1925		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County KENT		10c. City, Town or Location WORTON				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 24192 MACS LANE P.O. BOX 165				10f. Zip Code 21678		10g. Citizen of What Country? UNITED STATES			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR				16b. Kind of Business/Industry U.S. COAST GURAD	
	17. Father's Name (First, Middle, Last) WALTER JEDROWICZ					18. Mother's Name (First, Middle, Maiden Surname) HELEN SOWINSKI				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) VICTORIA JEDROWICZ/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24192 MACS LANE P.O. BOX 165 WORTON, MD 21678					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEM. PK.				20c. Location - City or Town, State GLEN BURNIE, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Septic shock Due to (or as a consequence of): b. Streptococcus Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number D55187		29d. Date signed (Month, Day, Year) November 3, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Yu 64 Franklin Street, Annapolis, MD 21401										
31. Date filed (Month, Day, Year) NOV 09 2000				32. Registrar's Signature 						

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35612

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Francis S. King				2. Date of Death Month Day Year November 9, 2000		3. Time of Death 7:00am	
	4a. Facility Name (If not institution, give street and number) 8110 North Boundary Road				4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-20-6208		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) 2-25-1928	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Dundalk	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 8110 North Boundary Road		10f. Zip Code 21222		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Navy		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist		16b. Kind of Business/Industry Bendix		17. Father's Name (First, Middle, Last) Norman King	
	18. Mother's Name (First, Middle, Maiden Surname) Anna Young		19a. Informant's Name/Relationship (Type, Print) Patricia King daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8110 North Boundary Road, Baltimore, MD. 21222		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Crownsville Va.		20c. Location - City or Town, State 11/13/00 Crownsville, MD		21. Signature of Funeral Service Licensee Joseph N. Zannino Jr.		22. Name and Address of Facility Joseph N. Zannino Jr. Funeral HM 263 South Conkling St. Baltimore, MD 21224	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Multiple Myeloma Due to (or as a consequence of): b. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 3 months		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier S. O'Connell	
	29c. License number D30641		29d. Date signed (Month, Day, Year) November 9 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMESH SABAPATHI 3400 EADMAN AVE. BALTIMORE MD 21215		31. Data filed (Month, Day, Year) NOV 09 2000	
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature J. Sparks		33. Registrar's Signature J. Sparks		34. Registrar's Signature J. Sparks		35. Registrar's Signature J. Sparks	
	36. Registrar's Signature J. Sparks		37. Registrar's Signature J. Sparks		38. Registrar's Signature J. Sparks		39. Registrar's Signature J. Sparks	

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State of Maryland / Department of Health and Mental Hygiene

00 35613

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM B KEATON				2. Date of Death Month October Day 30 Year 2000		3. Time of Death 347 Am	
	4a. Facility Name (If not institution, give street and number) MERCY MEDICAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 212-18-8458	6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1-9-1920		9. Birthplace (State or Foreign Country) Georgia
	Usual Residence of Decedent				10a. State MD.		10b. County BALTO.	
To Be Completed by Funeral Director	10c. City, Town or Location BALTO.				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 601 S. CHARLES	
	10f. Zip Code 21230				10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COOK		16b. Kind of Business/Industry RESTAURANT	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) ALBERT KEATON				18. Mother's Name (First, Middle, Maiden Surname) BESSIE BROWN			
	19a. Informant's Name/Relationship (Type, Print) MARCISSA WATKINS				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21231 201 N. WASHINGTON ST. BALTO. MD.			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST 11-800 Reisterstown MD		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee Wesley Charles				22. Name and Address of Facility CHARIS F. H. BALTO. MD 21231 2007 EASTERN AVE			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause for each line. Immediate Cause (Final disease or condition resulting in death) a. Ventricular Arrhythmia Due to (or as a consequence of): b. END Stage Renal Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No				28d. Describe how injury occurred			
State Registrar	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Amalinder MD				29c. License number AU4176435M13016		29d. Date signed (Month, Day, Year) October 30, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 ST PAUL PLACE BALTIMORE MARYLAND 21202							
31. Date filed (Month, Day, Year) NOV 09 2000				32. Registrar's Signature Sparks				

1-15-1919

1-15-1919

1-15-1919

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State of Maryland / Department of Health and Mental Hygiene

00 35614

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Marion Kerr				2. Date of Death Month Day Year November 06, 2000				3. Time of Death 1:27 PM		
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore Co.		
Funeral Director	5. Social Security Number 316-18-5646	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 31, 1923		9. Birthplace (State or Foreign Country) Oakland City, IN.			
	Usual Residence of Decedent										
10a. State Maryland		10b. County Baltimore Co.		10c. City, Town or Location Towson				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 1 Southerly Court Unit#503				10f. Zip Code 21286		10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1947-49		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical Doctor			16b. Kind of Business/Industry Medicine				
17. Father's Name (First, Middle, Last) Charles I. Kerr				18. Mother's Name (First, Middle, Maiden Surname) Maria Larche							
19a. Informant's Name/Relationship (Type, Print) Dortha Norma (nee Dobbs) Kerr (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Southerly Court Unit#503 Towson, Md. 21286							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		Date 11/07/2000		20c. Location - City or Town, State Towson, Maryland			
21. Signature of Funeral Service Licensee Jeffrey L. Gair				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Transitional cell Cancer of right Ureter Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 1 year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier W. A. R. Ley				29c. License number D25205		29d. Date signed (Month, Day, Year) November 6, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. R. Ley 6701 N. Charles St. Baltor md 21204											
State Registrar		31. Date filed (Month, Day, Year) NOV 06 2000		32. Registrar's Signature B. Sparks							

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 35615

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Andrew Merrill Lubelczyk						2. Date of Death Month Day Year November 5, 2000		3. Time of Death 12:50pm			
	4a. Facility Name (If not institution, give street and number) 9337 Steeple Court						4b. City, Town, or Location of Death Laurel		4c. County of Death Howard			
Funeral Director	5. Social Security Number 215-45-2709		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 5 Yrs.		8. Date of Birth (Month, Day, Year) August 23, 1995		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent						10a. State Maryland		10b. County Howard		10c. City, Town or Location Laurel	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						10e. Street and Number 9337 Steeple Court		10f. Zip Code 20723		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student	
To Be Completed by Physician/Medical Examiner	16b. Kind of Business/Industry Education						17. Father's Name (First, Middle, Last) Jeffrey Lubelczyk		18. Mother's Name (First, Middle, Maiden Surname) Julia Schroer			
	19a. Informant's Name/Relationship (Type, Print) Julia Lubelczyk/mother						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9337 Steeple Court Laurel, Maryland 20723					
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						20b. Place of Disposition (Name of cemetery, crematory or other place) Crestlawn Mem. Park		20c. Location - City or Town, State Marriottsville, Maryland		20d. Date Nov. 9, 2000	
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, Maryland 20707					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ENCEPHALOPATHY Due to (or as a consequence of): b. COMPLEX I MITOCHONDRIAL DISORDER Due to (or as a consequence of): c. EPILEPSIA PARTIALIS CONTINUA Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 17 MONTHS					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NEUROGENIC ILEUS						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined						28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred						28e. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and Title of certifier 		29c. License number D14086(MD)		29d. Date signed (Month, Day, Year) 11-5-2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL SCHNEIDER, MD 2 KNOLL NORTH DRIVE, COLUMBIA, MD						31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature 		21045	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35616

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Maxwell Lucas Jr.		2. Date of Death Month Day Year November 06, 2000		3. Time of Death 5:07 P.M.
	4a. Facility Name (If not institution, give street and number) 402 Haslett Road		4b. City, Town, or Location of Death Joppa		4c. County of Death Harford
Funeral Director	5. Social Security Number 216-20-3010	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) March 28 1927		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10a. State MD		10b. County Harford		10c. City, Town or Location Joppa	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 402 Haslett Road			10f. Zip Code 21085		10g. Citizen of What Country? USA
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry State of Maryland	
17. Father's Name (First, Middle, Last) James M. Lucas Sr.			18. Mother's Name (First, Middle, Maiden Surname) Ethel HARE		
19a. Informant's Name/Relationship (Type, Print) Ronald Stansbury / nephew			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1236 Dansel Road Baltimore MD. 21221		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		20c. Location - City or Town, State Baltimore MD	
21. Signature of Funeral Service Licensee R. Terry Connolly		22. Name and Address of Facility Connolly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? Inspection <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier [Signature]		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) November 08, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Fowler, M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature [Signature]			

ORIGINAL

00 35617

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35618

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLIFTON BEVLON MCLAURIN				2. Date of Death Month Day Year NOV. 4 2000		3. Time of Death 9:30am	
	4a. Facility Name (If not institution, give street and number) 4304 SPRINGDALE AVENUE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA	
Funeral Director	5. Social Security Number 218-36-6570		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 60		8. Date of Birth (Month, Day, Year) JUNE 29, 1940	
	9. Birthplace (State or Foreign Country) N.C.		10a. State MD		10b. County NA		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 4304 SPRINGDALE AVENUE			
	10f. Zip Code 21207				10g. Citizen of What Country? U S A			
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LANDSCAPER		16b. Kind of Business/Industry SELF-EMPLOYED			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) SAMUEL MCLAURIN, SR.				18. Mother's Name (First, Middle, Maiden Surname) RACHEL SMALL			
	19a. Informant's Name/Relationship (Type, Print) JULIUS MCLAURIN - BROTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3406 DAYTA DRIVE BALTO., MD 21207			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Veteran		Date 11-14-00		20c. Location - City or Town, State Owings Mills, Md	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility MARCH FUNERAL HOME WEST, INC. 4300 WABASH AVE. BALTO., MD 21215					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause for each line. lung cancer Due to (or as a consequence of): Prostate cancer Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):						Approximate Interval Between Onset and Death 3 months	
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier Asha Murthy	
	29c. License number AY4635427						29d. Date signed (Month, Day, Year) 11/6/00	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHA MURTHY M.D., V.A. HOSPITAL GREENE ST. BALTIMORE, MD 21201							
	31. Date filed (Month, Day, Year) NOV 09 2000				32. Registrar's Signature <i>[Signature]</i>			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 35619

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lynda G McCartney			2. Date of Death Month Day Year November 4 2000		3. Time of Death 200 pm	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center			4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-60-6252	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 9 1952	9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent						
10a. State Md		10b. County Baltimore		10c. City, Town or Location Middle River		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 15 Cool Breeze Drive				10f. Zip Code 21220		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry own home		
17. Father's Name (First, Middle, Last) Ernest Miller				18. Mother's Name (First, Middle, Maiden Surname) Elsie Spencer			
19a. Informant's Name/Relationship (Type, Print) William McCartney / husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Cool Breeze Drive Baltimore Md. 21220			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 11/8/2000		20c. Location - City or Town, State Baltimore MD	
21. Signature of Funeral Service Licensee R. Terry Connelly				22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Pancreatitis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 3 Days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier M. McDonald, MD				29c. License number RD 192658		29d. Date signed (Month, Day, Year) November 4 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR Madai Char Don 9000 Franklin Square Drive Baltimore Maryland 21237							
31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature Beverly S. Sparks					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35620

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GERTRUDE MASERITZ				2. Date of Death Month 11 Day 6 Year 2000		3. Time of Death 6:15 AM		
	4a. Facility Name (If not institution, give street and number) MULTI MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 212-52-9827		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) OCT. 15, 1908		
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location TOWSON		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 7700 YORK ROAD		10f. Zip Code 21204		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME		17. Father's Name (First, Middle, Last) JACOB MILLER		18. Mother's Name (First, Middle, Maiden Surname) MINNIE (UNKNOWN)	
19a. Informant's Name/Relationship (Type, Print) GUY MASERITZ / SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5040 RUSHLIGHT PATH - COLUMBIA, MD 21044		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BETH JACOB CEMETERY		20c. Location - City or Town, State 11/8/00 FINKSBURG, MD	
21. Signature of Funeral Service Licensee <i>Jan Alan Lewis</i>		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pneumonia Due to (or as a consequence of): Dementia Bipolar Disorder Parkinsonism		Approximate Interval Between Onset and Death 1 week weeks			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Bipolar Disorder Parkinsonism		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, lecture, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Paul Schwartz</i>		29c. License number D17118		29d. Date signed (Month, Day, Year) Nov 6, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Schwartz M.D. 115 E Melrose Ave 21212		31. Date filed (Month, Day, Year) NOV 08 2000		32. Registrar's Signature <i>B. Sparks</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35621

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARTHA ELLEN MANNER				2. Date of Death Month Day Year November 6, 2000		3. Time of Death 1:10 PM	
	4a. Facility Name (If not institution, give street and number) Oak Crest Village Care Center				4b. City, Town, or Location of Death Parkville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-05-9315	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 3, 1919	9. Birthplace (State or Foreign Country) Md.	
	Usual Residence of Decedent							
10a. State Md.		10b. County Baltimore		10c. City, Town or Location Parkville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 8800 Walther Blvd.				10f. Zip Code 21234		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home maker		16b. Kind of Business/Industry Own home		
17. Father's Name (First, Middle, Last) John Martin				18. Mother's Name (First, Middle, Maiden Surname) Sarah Brawner				
19a. Informant's Name/Relationship (Type, Print) Mr. Ellwood L. Manner/husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Springtowne Cr. Apt. 3-B Baltimore, Md. 21234				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. Location - City or Town, State 11/10/00 Parkville, Md.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>End Stage Alzheimer's Disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D16619		29d. Date signed (Month, Day, Year) November 6, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. VERGARA-SOARES 8832 WALTHER BLVD. PARKVILLE, MD. 21234								
State Registrar		31. Date filed (Month, Day, Year) NOV 06 2000		32. Registrar's Signature 				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35622

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Herminia Narvaez		2. Date of Death Month Day Year November 7, 2000		3. Time of Death 0645 AM
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital		4b. City, Town, or Location of Death Baltimore City		4c. County of Death
Funeral Director	5. Social Security Number 582-34-6206	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Nov. 12, 1928		9. Birthplace (State or Foreign Country) Puerto Rico		
Usual Residence of Decedent					
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Pasadena	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 822 220th Street		10f. Zip Code 21122		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Puerto Rican	
14. Race - American Indian, Black, White, etc. Specify:					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	
16b. Kind of Business/Industry Own Home					
17. Father's Name (First, Middle, Last) Alejandro Narvaez			18. Mother's Name (First, Middle, Maiden Surname) unknown		
19a. Informant's Name/Relationship (Type, Print) Jenny Reyes - daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7520 Baleen Ct., Glen Burnie, MD 21061		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Municipal Cemetery		20c. Location - City or Town, State 11/11 Toa Alta, Puerto Rico	
21. Signature of Funeral Service Licensee Kelly Gregory Fink		22. Name and Address of Facility FINK FUNERAL HOME, PA 426 Crain Hwy., SW, Glen Burnie, MD 21061			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. Retroperitoneal hemorrhage			Approximate Interval Between Onset and Death 2 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. atherosclerotic cardiovascular disease			10 years
c.		Due to (or as a consequence of):			
d.		Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
Coronary artery disease					
peripheral vascular disease					
abdominal aortic aneurysm					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Assistant Director, ICU Peter J. Sloane MD		29c. License number MD41593		29d. Date signed (Month, Day, Year) November 7, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter J. Sloane, 3333 N Calvert St #650 Baltimore, MD 21218					
31. Date filed (Month, Day, Year) NOV 06 2000		32. Registrar's Signature [Signature]			

ORIGINAL

00-6197-510

cm

Junior P. Owens

amend item 23a, pt II, 27 per me G789 11/13/00 yf

k

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State of Maryland / Department of Health and Mental Hygiene

00 35623

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Junior P. Owens

2. Date of Death

Month Day Year
October 31, 2000

3. Time of Death

8:31 A.M.

4a. Facility Name (If not institution, give street and number)

548 Gold Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

217-66-7084

6. Sex

X ☒ M ☐ F

7. Age (In yrs. last birthday)

43

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
11-24-56

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

584 Gold Street

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8th GradeCollege (1-4 or 5+)
NA16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

various trades

17. Father's Name (First, Middle, Last)

Purdie Owens, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lena Harrison

19a. Informant's Name/Relationship (Type, Print)

Clara A. Bivens

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2749 The Alameda Baltimore, Maryland 21218

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Voshell Mem. Gardens 11-08-2000 Dundalk, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Gladys Wane

22. Name and Address of Facility

Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. DIABETIC KETOACIDOSIS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ALCOHOLISM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. LARON LOCKE MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

October 31, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. LARON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

NOV 09 2000

32. Registrar's Signature

J. LARON LOCKE MD

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35624

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LAWRENCE MELVIN OSTERLOH

2. Date of Death

Month Day Year
NOVEMBER 8, 2000

3. Time of Death

1325 Hrs

4a. Facility Name (If not Institution, give street and number)

NORTHWEST HOSPITAL

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

214-18-2518

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

12-7-1920

9. Birthplace (State or Foreign Country)

Baltimore, MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Windsor Mill

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7430 Hindon Circle Apt. #103

10f. Zip Code

21244

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Highway Designer

16b. Kind of Business/Industry

Highway Design;
Private Contractor

17. Father's Name (First, Middle, Last)

Walter Osterloh

18. Mother's Name (First, Middle, Maiden Surname)

Louisa Goodrich

19a. Informant's Name/Relationship (Type, Print)

Ann L. Shrieves Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3100 Keswick Road Baltimore, Maryland 21211

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

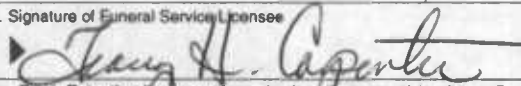
cemetery, crematory or other place)

Baltimore-Washington 11/13/00 Laurel, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Burgee-Henss-seitz Funeral Home, Inc.
3631 Falls Road Baltimore, MD 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

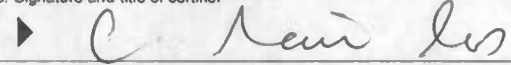
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D37333

29d. Date signed (Month, Day, Year)

NOVEMBER 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. DAVIS, MHC, BALTO. MD 21133

31. Date filed (Month, Day, Year)

NOV 09 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35625

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BERNARD ALONZO OVERTON, SR.				2. Date of Death Month Day Year November 6, 2000		3. Time of Death 2:12 pm	
	4a. Facility Name (If not institution, give street and number) STELLA MARIS @ MERCY HOSPICE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA	
Funeral Director	5. Social Security Number 218-14-8397		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) AUG 17 1922	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 319 WELLHAM AVE.		10f. Zip Code 21061	
	10g. Citizen of What Country? U S A				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) NA	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNKNOWN				16b. Kind of Business/Industry		17. Father's Name (First, Middle, Last) ALONZO A. OVERTON	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) DOROTHY FALLIN				19a. Informant's Name/Relationship (Type, Print) HELEN OVERTON - WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 319 WELLHAM AVE. GLEN BURNIE, MD 21061	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY		20c. Location - City or Town, State 11-10-00 GLEN BURNIE, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility MARCH FUNERAL HOME WEST, INC. 4300 WABASH AVE. BALTO., MD 21215		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic bladder cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify hospice)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of Certifier <i>[Signature]</i>	
To Be Completed by Physician/Medical Examiner	29c. License number D40854				29d. Date signed (Month, Day, Year) 11/7/2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Roseberg 301 St Paul Pl Baltimore, MD 21202	
	31. Date filed (Month, Day, Year) NOV 09 2000				32. Registrar's Signature <i>[Signature]</i>			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35626

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lillie F. O'Donnell				2. Date of Death Month Day Year Nov 8, 2000		3. Time of Death 12:35 AM		
	4a. Facility Name (If not institution, give street and number) St. Elizabeth Rehabilitation & Nursing Home				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City		
Funeral Director	5. Social Security Number 012-28-3639		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Oct 27, 1928		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Howard		10c. City, Town or Location Ellicott City		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4652 Sheppard Lane		10f. Zip Code 21042		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry Public Schools		17. Father's Name (First, Middle, Last) Lee Whitworth Freund		
	18. Mother's Name (First, Middle, Maiden Surname) Helen D. Kemp		19a. Informant's Name/Relationship (Type, Print) Mr. Charles H. O'Donnell		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4652 Sheppard Lane Ellicott City, Maryland 21042		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation Services, Inc.		20c. Date 11/08/00		20d. Location - City or Town, State Sykesville, Maryland		21. Signature of Funeral Service Licensee Timothy S. H. 11/11/03		
	22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia Due to (or as a consequence of): Multiple Sclerosis Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 10 hours		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
State Registrar	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Edmund P. O'Donnell		
	29c. License number D34951		29d. Date signed (Month, Day, Year) 11-8-2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDMUND P. O'DONNELL 405 Federal Rd Suite 100 Catonsville MD 21228		31. Data filed (Month, Day, Year) NOV 09 2000		
32. Registrar's Signature [Signature]		33. Registrar's Signature [Signature]		34. Registrar's Signature [Signature]		35. Registrar's Signature [Signature]		36. Registrar's Signature [Signature]	

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35627

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EMMA M. PEMBERTON				2. Date of Death Month 11 Day 3 Year 2000				3. Time of Death 6:50	
	4a. Facility Name (If not institution, give street and number) GENESIS HAMILTON CENTER				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-12-0175		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) 7/25/07		9. Birthplace (State or Foreign Country) VA							
To Be Completed by Funeral Director	Usual Residence of Decedent									
	10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1100 Pennsylvania Ave - Apt 1503				10f. Zip Code 21201				10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper				16b. Kind of Business/Industry Private Duty			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Robert Lyles				18. Mother's Name (First, Middle, Maiden Surname) Sadie Lyles					
	19a. Informant's Name/Relationship (Type, Print) Edward N. Rich / son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4913 Sinclair Lane, Balt. MD 21206					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Western Star Cem.		Date 11/9/2000		20c. Location - City or Town, State Catonsville, MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hart P. Chase Funeral Service, P.A. 709 Tessier St., Balt., MD 21201					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Arrhythmia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 6 months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number D45475		29d. Date signed (Month, Day, Year) 11/6/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammad Rahwana 8100 Harbor Rd 21234										
31. Date filed (Month, Day, Year) Nov 9 2000		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35628

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KATE PENN				2. Date of Death Month 11 Day 7 Year 2000		3. Time of Death 1230 AM	
	4a. Facility Name (If not institution, give street and number) MILLENNIUM NURSING HOME				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA	
Funeral Director	5. Social Security Number 213-74-0202		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 103 Yrs.		8. Date of Birth (Month, Day, Year) DEC 6 1896	
	9. Birthplace (State or Foreign Country) N.C.		10e. State MD		10b. County NA		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 3812 WOODHAVEN AVE.		10f. Zip Code 21216		10g. Citizen of What Country? U S A	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th		College (1-4or 5+) NA		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		16b. Kind of Business/Industry AT HOME	
	17. Father's Name (First, Middle, Last) HENDERSON TUCKER				18. Mother's Name (First, Middle, Maiden Surname) HARRIET			
	19a. Informant's Name/Relationship (Type, Print) HAZEL N. WILLIAMS-DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3812 WOODHAVEN AVE. BALTO., MD 21216			
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) DRUID RIDGE CEMETERY		Date 11-9-00		20c. Location - City or Town, State BALTO., MD	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility MARCH FUNERAL HOME WEST, INC. 4300 WABASH AVE. BALTO., MD 21215			
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. FAILURE-TO-THRIVE Due to (or as a consequence of): b. ADVANCED ALZHEIMERS DEMENTIA Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STAGE IV SACRAL DECUBITUS ULCER							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number 145931		29d. Date signed (Month, Day, Year) November 8, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEBORAH I PILICE 7220 PARK HEIGHTS AVENUE BALTIMORE MD.								
31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature <i>[Signature]</i>						

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State of Maryland / Department of Health and Mental Hygiene

00 35629

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LILLIAN M. RIGGIN						2. Date of Death Month Day Year NOVEMBER 4, 2000		3. Time of Death 6:00 A.M.	
	4a. Facility Name (If not institution, give street and number) MERCY MEDICAL CENTER						4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE CITY	
Funeral Director	5. Social Security Number 214-26-9853		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) JULY 9, 1929		9. Birthplace (State or Foreign) MARYLAND	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 102 GARRETT ROAD				10f. Zip Code 21060		10g. Citizen of What Country? UNITED STATES			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FOOD LINE SUPERVISOR			16b. Kind of Business/Industry FOOD SERVICE		
	17. Father's Name (First, Middle, Last) JOHN DEBUS					18. Mother's Name (First, Middle, Maiden Surname) SOPHIA HUTTON				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) DANNY RIGGIN/SON					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7606 NOTHWOOD EST. CT. SEVERN, MD 21144				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEM. PK.			20c. Date NOV. 7, 2000		20d. Location - City or Town, State GLEN BURNIE, MD	
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME PA 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardio Respiratory Arrest Due to (or as a consequence of): b. VULVAR CANCER Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number 1108372		29d. Date signed (Month, Day, Year) NOVEMBER 5, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil B. Krasnowski, Mercy Medical Center, 301 St. Paul St., Balto, Md.									
	31. Date filed (Month, Day, Year) NOV 09 2000					32. Registrar's Signature 				

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State of Maryland / Department of Health and Mental Hygiene 00 35630
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Roxanis				2. Date of Death Month Day Year NOVEMBER 8, 2000				3. Time of Death 12:50 AM	
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 235-20-8873		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) November 26, 1923		9. Birthplace (State or Foreign Country) McKeesport, PA.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore Co.		10c. City, Town or Location Towson				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 205 East Joppa Road Suite 2304				10f. Zip Code 21286		10g. Citizen of What Country? United States of America			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: W.W.II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 03				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self Employed			16b. Kind of Business/Industry Food Service/Dunkin Donuts		
	17. Father's Name (First, Middle, Last) Gust Roxanis				18. Mother's Name (First, Middle, Maiden Surname) Angelina Apossos					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) (Wife) Judith Lorraine(nee Bierman)Roxanis				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 East Joppa Road Suite 2304 Towson, Maryland 21286					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Greek Orthodox Cemetery		20c. Location - City or Town, State 11/11/2000 Woodlawn, Maryland			
	21. Signature of Funeral Service Licensee Jeffrey L. Gair				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204					
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE a. Due to (or as a consequence of): REFRACTORY METABOLIC ACIDOSIS b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. GASTROINTESTINAL BLEEDING RENAL FAILURE									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certify (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier A. J. Helou, M.D.				29c. License number D 17695				29d. Date signed (Month, Day, Year) November 8, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDALLAH J. HELOU, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204									
31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature B. Sparks								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35631

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edmund Burleigh Ryder				2. Date of Death Month November Day 4 Year 2000		3. Time of Death 10:10 P.M.	
	4a. Facility Name (If not institution, give street and number) Morningside House				4b. City, Town, or Location of Death Hanover		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 264 28 4486		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 15, 1917	
	9. Birthplace (State or Foreign Country) Massachusetts		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Hanover	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 7548 Old Telegraph Road Apt. 321			
	10f. Zip Code 21076				10g. Citizen of What Country? U.S.			
	11. Mental Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+) 4 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Drummer		16b. Kind of Business/Industry Army Band	
	17. Father's Name (First, Middle, Last) Oscar H. Ryder				18. Mother's Name (First, Middle, Maiden Surname) Adeline Shaw			
	19a. Informant's Name/Relationship (Type, Print) Laura Burger / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7865 Hidden Creek Way Baltimore, Maryland 21226			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem.		20c. Location - City or Town, State 11/15/00 Arlington, Virginia	
	21. Signature of Funeral Service Licensee <i>Donna M. Branich</i>				22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225			
	23a. Part I. Enter the disease, or combination of diseases that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PANCREATIC CANCER Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death 6 MONTHS			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ASSISTED LIVING						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Albin Kuhn M.D.</i>				29c. License number D0021336		29d. Date signed (Month, Day, Year) 11/6/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALBIN KUHN II MD, 8028 RITCHIE HIGHWAY, PASADENA, MARYLAND 21122								
31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature <i>Benjamin G. Sparks</i>						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35632

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward G. Staiger				2. Date of Death Month November Day 8 Year 2000		3. Time of Death 1:30 AM	
	4a. Facility Name (If not institution, give street and number) Genesis Elder Care-Severna Park Center				4b. City, Town, or Location of Death Severna Park		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 217-03-8879		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) MAR 22, 1911	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Linthicum	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 546 Forest View Road		10f. Zip Code 21090		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist		16b. Kind of Business/Industry Factory			
	17. Father's Name (First, Middle, Last) George Staiger				18. Mother's Name (First, Middle, Maiden Surname) Elenore Anderson			
	19a. Informant's Name/Relationship (Type, Print) Mary E. Duvall/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 546 Forest View Road Linthicum, MD 21090			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		Date 11-8-00		20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee Thomas Gregor		22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension Severe Vascular Dementia							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier John F. Loane, MD				29c. License number D52728		29d. Date signed (Month, Day, Year) November 8, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John F. Loane, MD 479 Jumper's Hole Road #304 Severna Park, MD 21146							
31. Date filed (Month, Day, Year) NOV 08 2000		32. Registrar's Signature Benjamin S. Sparks						

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State of Maryland / Department of Health and Mental Hygiene

amend item 23a,PtII, 28a,b,c,d,e,f, per me G789 11/29/00

Certificate of Death

Reg. No. 00 35633

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Andrew Swanek				2. Date of Death Month Day Year NOVEMBER 05, 2000				3. Time of Death 5:35 P.M.		
	4a. Facility Name (If not institution, give street and number) 18001 COTTAGE GARDEN DRIVE APARTMENT #104				4b. City, Town, or Location of Death GERMANTOWN				4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 206-40-1677		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) MAR 9, 1950		9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent				10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Germantown		
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
10e. Street and Number 14520 Bellmeade Lane				10f. Zip Code 20874				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5 +				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanical Engineer				16b. Kind of Business/Industry Defense Research			
17. Father's Name (First, Middle, Last) Andrew Richard Swanek					18. Mother's Name (First, Middle, Maiden Surname) Helen Tylka						
19a. Informant's Name/Relationship (Type, Print) Anne D. Swanek/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14520 Bellmeade Lane Germantown, MD 20874							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		20c. Location - City or Town, State 11-8-00 Baltimore, MD					
21. Signature of Funeral Service Licensee Edward A. Gregorchik				22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHRONIC ALCOHOLISM ASSOCIATED WITH MULTIPLE INJURIES Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) found: 11/5/00		28b. Time of Injury at Work? unknown M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject fell several times	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence				28f. Location (Street and Number or Rural Route Number, City or Town, State) 18001 Cottage Garden Drive, Apt. #104, Germantown, Md Montgomery County,							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Stephen S. Radentz				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) NOVEMBER 06, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) NOV 08 2000				32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-697-0000.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item#19b per FHG789 11/17/2000 EW

State of Maryland / Department of Health and Mental Hygiene

00 35634

Amended Item#7 per FHG789 11/9/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Kenneth Smith Sr.</i>				2. Date of Death Month <i>November</i> Day <i>5</i> Year <i>2000</i>		3. Time of Death <i>2:20 PM</i>		
	4a. Facility Name (If not institution, give street and number) <i>VAMC - Baltimore</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>NA</i>		
Funeral Director	5. Social Security Number <i>220-36-9356</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>59</i> <i>60</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>12/08/40</i>	9. Birthplace (State or Foreign Country) <i>MD</i>	
	Usual Residence of Decedent								
10a. State <i>MD</i>		10b. County <i>NA</i>		10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <i>845 McAleer Court</i>				10f. Zip Code <i>21202</i>		10g. Citizen of What Country? <i>USA</i>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11th Grade</i> College (1-4 or 5+) <i>NA</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Bus Driver</i>		16b. Kind of Business/Industry <i>Baltimore City Public School</i>			
17. Father's Name (First, Middle, Last) <i>Leonard Green</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Amelia Smith</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Kenneth M. Smith, Jr.</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>204 Plantation Lane Springfield, VA 23430</i> <i>Smithfield</i>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>King Mem. Pk. Cemetery</i>		20c. Location - City or Town, State <i>11-10-2000 Randallstown MD.</i>				
21. Signature of Funeral Service Licensee <i>Shirley Wane</i>				22. Name and Address of Facility <i>Baltimore, Maryland 21202</i> <i>WM.C. March FH 1101 E. North Avenue</i>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Lung Cancer</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d.</i>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>P12446</i>		29d. Date signed (Month, Day, Year) <i>November 5, 2000</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>T. Mattingly MD 22 South Green St Baltimore, MD 21201</i>									
31. Date filed (Month, Day, Year) <i>NOV 09 2000</i>				32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35635

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anthony Charles Shields				2. Date of Death Month Day Year Nov. 8, 2000				3. Time of Death 7:11AM	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital ER				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-36-3669		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 21, 1935		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 3653 Malden Avenue				10f. Zip Code 21211	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korea	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (1-4 or 5+) 	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fire Fighter				16b. Kind of Business/Industry Fire Department Baltimore City				17. Father's Name (First, Middle, Last) Charles Shields	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Lena Calp				19a. Informant's Name/Relationship (Type, Print) Elizabeth Shields Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3653 Malden Avenue Baltimore, MD 21211	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore-Washington				20c. Location - City or Town, State 11/13/00 Laurel, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211				23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Kennilular Amyloidosis</i> Due to (or as a consequence of): b. <i>Chronic Arteriosclerosis</i> Due to (or as a consequence of): c. <i>Chronic Arteriosclerosis</i> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Type II Diabetes Mellitus</i> <i>CCPD</i>				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number 016248				29d. Date signed (Month, Day, Year) 11/9/00	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 805 W. 32nd St. Baltimore, Md. 21071				31. Date filed (Month, Day, Year) NOV 09 2000				32. Registrar's Signature <i>[Signature]</i>	
	State Registrar									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35636

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LULA G. SMITH

2. Date of Death
Month Day Year
NOVEMBER 1, 20003. Time of Death
11:05 PM

4a. Facility Name (If not institution, give street and number)

Manorcare Rossville

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

180-01-8796

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug 7, 1908

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6600 Ridge Road

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
6College (1-4 or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

seamstress

16b. Kind of Business/Industry

garment

17. Father's Name (First, Middle, Last)

Grant Hare

18. Mother's Name (First, Middle, Maiden Surname)

Katie Hare

19a. Informant's Name/Relationship (Type, Print)

Edward Funk/nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16 Shoreham Court Nottingham, MD 21236

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Coronary Artery Disease

4 years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number

DS3462

29d. Date signed (Month, Day, Year)

11/03/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jude Muneses MD 7845 Oakwood Road Glen Burnie MD 21061

State
Registrar

31. Date filed (Month, Day, Year)

NOV 09 2000

32. Registrar's Signature

Benjamin G. Sparks

DOB: 10/11/1908 Exp: 11/1/00 11:05 AM

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be accurate within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#18 perABG789 11/13/2000 EW

Certificate of Death

Reg. No.

00 35637

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDYTHE SANDERS				2. Date of Death Month Day Year November 5, 2000		3. Time of Death 7:10 AM	
	4a. Facility Name (If not institution, give street and number) Heritage Nursing Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 112-03-0824		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept 13, 1914	9. Birthplace (State or Foreign Country) NY
	Usual Residence of Decedent							
10a. State MD		10b. County		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 7232 German Hill Road				10f. Zip Code 21222		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) stenographer			16b. Kind of Business/Industry legal	
17. Father's Name (First, Middle, Last) Jacob Wineberg				18. Mother's Name (First, Middle, Maiden Surname) Mary (UNK)				
19a. Informant's Name/Relationship (Type, Print) Cyrus Sanders/spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3504 Esther Place Baltimore, MD 21224				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)								
a. RESPIRATORY FAILURE Due to (or as a consequence of):								
b. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of):								
c. DEMENTIA Due to (or as a consequence of):								
d. GASTROSTOMY TUBE PLACEMENT								
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Sarinder K Tuli M.D.				29c. License number 527188		29d. Date signed (Month, Day, Year) 11/6/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sarinder K Tuli 2 Market Place Baltimore MD 21222								
31. Date filed (Month, Day, Year) NOV 09 2000				32. Registrar's Signature Benjamin B. Sparks				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35638

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANTHONY DANIEL SINISI				2. Date of Death Month Day Year Nov. 5 2000		3. Time of Death 6:00am	
	4a. Facility Name (If not institution, give street and number) 98 Berkshire Road				4b. City, Town, or Location of Death Essex		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 185-14-6920		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) July 31 1922	
	10e. State MD		10b. County Baltimore		10c. City, Town or Location Essex		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2yrs				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry Martin's	
	17. Father's Name (First, Middle, Last) Michele A Sinisi				18. Mother's Name (First, Middle, Maiden Surname) Rosina Musto			
	19a. Informant's Name/Relationship (Type, Print) Betty Sinisi / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 98 Berkshire Road Baltimore Md. 21221			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Cemetery		Date 11/8/2000		20c. Location - City or Town, State Baltimore Md	
	21. Signature of Funeral Service Licensee R. Terry Connolly				22. Name and Address of Facility Connolly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
	23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Metastatic Colon Ca				Approximate Interval Between Onset and Death 2 years			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier MD				29c. License number D18487		29d. Date signed (Month, Day, Year) 11/6/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYO THANT 6830 HOSPITAL DRIVE, BALTO, MD 21237								
31. Date filed (Month, Day, Year) NOV 09 2000				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35639

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carra H. Seibert				2. Date of Death Month NOV Day 7 Year 2000		3. Time of Death 2330		
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 215-12-4993	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) DEC. 2, 1922		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent				10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location HANOVER
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 175 CHESAPEAKE MOBIL CT.		10f. Zip Code 21076		10g. Citizen of What Country? UNITED STATES
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CAFETERIA WORKER		16b. Kind of Business/Industry ANNE ARUNDEL COUNTY BOARD OF EDUCATION		
	17. Father's Name (First, Middle, Last) CHARLES HALL				18. Mother's Name (First, Middle, Maiden Surname) ROSA IRELAND				
	19a. Informant's Name/Relationship (Type, Print) ROBIN J. HALL / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 175 CHESAPEAKE MOBIL CT., HANOVER, MARYLAND 21076				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE NATIONAL CEM.		Date NOV. 10 2000		20c. Location - City or Town, State BALTIMORE, MARYLAND		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Asystolic Cardiac Arrest Due to (or as a consequence of): b. End-Stage Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2 hours 2 years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number D28000		29d. Date signed (Month, Day, Year) November 7, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARC OKUN MD 203 HOSPITAL DRIVE SUITE 206 GLEN BURNIE, MARYLAND 21061									
31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature 							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35640

amend item 23a,ptII,28a,b,c,d,e,f per me G789 11/14/00 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANK SILBERHOLZ				2. Date of Death Month: November Day: 02 Year: 2000				3. Time of Death 01:21 P.M.		
	4a. Facility Name (If not institution, give street and number) 312 New Jersey Avenue N.E.				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 575-16-3422	6. Sex XX M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) 8/8/1919	9. Birthplace (State or Foreign Country) NEW JERSEY				
	Usual Residence of Decedent										
10a. State MD		10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 312 NEW JERSEY AVENUE				10f. Zip Code 21060		10g. Citizen of What Country? USA					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+):				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ELECTRICAL ENGINEER			16b. Kind of Business/Industry COPPERS CO.				
17. Father's Name (First, Middle, Last) UNKNOWN				18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN							
19a. Informant's Name/Relationship (Type, Print) FRANCIS M. SILBERHOLZ - SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 917 WINDSOR AVE., ANNAPOLIS, MD 21403							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):				20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND VETERAN CEM.		Date 11/8		20c. Location - City or Town, State CROWNSVILLE, MD			
21. Signature of Funeral Home Licensee  KELLY GREGORY FINK				22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HWY., SW, GLEN BURNIE, MD 21061							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONTACT GUNSHOT WOUND OF HEAD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
							24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Scene							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 11/2/00		28b. Time of Injury unknown M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject shot self			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence				28f. Location (Street and Number or Rural Route Number, City or Town, State) 312 New Jersey Avenue, Glen Burnie, Anne Arundel County, Md.							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier  Stephen S. Radentz, M.D.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) November 3, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) NOV 09 2000				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Ch. Duguet

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35641

amend item 6 per fh G789 11/22/00 yf

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Angela C. Seta		2. Date of Death Month Day Year November 4 2000		3. Time of Death 11:30PM
	4a. Facility Name (If not institution, give street and number) Crofton Convalescent Center		4b. City, Town, or Location of Death Crofton		4c. County of Death Anne Arundel
Funeral Director	5. Social Security Number 215-58-2137	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	8. Date of Birth (Month, Day, Year) Aug. 2 1913	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Md.	10b. County Anne Arundel	10c. City, Town or Location Annapolis		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 85 Manresa Rd.		10f. Zip Code 21401		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) +3		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Harry D'Adamio		18. Mother's Name (First, Middle, Maiden Surname) Mary Cieri		
	19a. Informant's Name/Relationship (Type, Print) Mrs. Roslyn Theriot/ Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 627 Oyster Cove Dr. Grasonville, Md. 21638		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gdns.		20c. Location - City or Town, State 11-8-00 Timonium, Md.
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Terminal Lymphoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death years.		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Rakesh Arora MD		29c. License number D20108	29d. Date signed (Month, Day, Year) 11/6/00
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAKESH ARORA, MD 14300 GALLANT FOX LANE, BOWIE MD 20715					
State Registrar	31. Date filed (Month, Day, Year) NOV 06 2000		32. Registrar's Signature 		

ORIGINAL

Please Type or Print in Black Indellible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35642

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rita Sobczak

2. Date of Death

11 04 00

3. Time of Death

12:30 am

4a. Facility Name (If not institution, give street and number)

University of Maryland Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

218-22-4540

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 22, 1927

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

346 HORNEL STREET

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

PRINTER

16b. Kind of Business/Industry

PRINTING COMPANY

17. Father's Name (First, Middle, Last)

MICHAEL NAPOLI

18. Mother's Name (First, Middle, Maiden Surname)

JOSEPHINE (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

RICHARD DARNELL - HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

346 HORNEL STREET BALTIMORE, MARYLAND 21224

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

OAK LAWN CEMETERY

Date

11/6/00

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Elizabeth Selinski

22. Name and Address of Facility

CHARLES S. ZEILER & SON, INC.

6224 EASTERN AVE. BALTIMORE, MD 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Metastatic Liver Adenocarcinoma

Due to (or as a consequence of):

b. Sepsis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. Espy-Smith MD

29c. License number

P13374

29d. Date signed (Month, Day, Year)

11/4/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Espy-Smith MD 22 South Green Street Baltimore, MD 21201

State
Registrar

31. Date filed (Month, Day, Year)

NOV 09 2000

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35643

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gertrude Arlene Turner				2. Date of Death Month Day Year NOVEMBER 7, 2000				3. Time of Death 1:20 AM	
	4a. Facility Name (If not institution, give street and number) Doctors Hospital				4b. City, Town, or Location of Death Lanham				4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 120-26-0647		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) MAR 11, 1931		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent				10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Upper Marlboro	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 2802 Hatboro Place				10f. Zip Code 20772	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+) Collega (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Health Aid				16b. Kind of Business/Industry State of Maryland				17. Father's Name (First, Middle, Last) Edward L. Bess	
	18. Mother's Name (First, Middle, Maiden Surname) Ida V. Dandridge				19. Injorment's Name/Relationship (Type, Print) Vallorie Turner Sims/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 821 E. Main St. Apt#9B River Head, NY 11901	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.				20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee Edward A. Gregorich				22. Name and Address of Facility Cremation Society of MD, Inc.				22. Name and Address of Facility 299 Frederick Road Baltimore, MD 21228	
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. TERMINAL LUNG CANCER				Approximate Interval Between Onset and Death 6 MONTHS					
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24e. Were an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of injury (Month, Day, Year) 11/7/00				28b. Time of injury M		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier MD				29c. License number 01715		
29d. Date signed (Month, Day, Year) 11. 7. 00				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHITRA VENKATRAMAN MD COLLEGE PARK MD 20740				31. Date filed (Month, Day, Year) NOV 08 2000		
32. Registrar's Signature B. Sparks										

2000 NOV -9 PM 12:23

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35644

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM F. TIERNEY				2. Date of Death Month NOVEMBER Day 6 Year 2000		3. Time of Death 9:02 P.M.	
	4a. Facility Name (If not Institution, give street and number) GILCHRIST CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 218-10-3267		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) 4/6/20	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location RIDGELEIGH	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 1718 WESTON AVENUE		10f. Zip Code 21234	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) 12TH GRADE	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INSIDE SALES				16b. Kind of Business/Industry CROWN, CORK & SEAL		17. Father's Name (First, Middle, Last) JOHN TIERNEY	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) CATHERINE MESKILL				19a. Informant's Name/Relationship (Type, Print) MARY ZALOSKI DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1550 BENTLEY AVENUE BELAIR, MD 21015	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) DULANEY VALLEY MEM. GAR.		20c. Location - City or Town, State 11/10/00 COCKEYSVILLE, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Heather N. Hay</i>				22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last e. Squamous cell cancer of Due to (or as a consequence of): f. Liver from unknown Due to (or as a consequence of): g. primary site Due to (or as a consequence of): h. 3 months				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Hospice			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and Title of Certifier <i>W.A. Riley, MD</i>			
	29c. License number 025205				29d. Date signed (Month, Day, Year) November 7, 2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley GBMC 6701 N. Charles St. Balto. md 2120x				31. Date filed (Month, Day, Year) NOV 09 2000			
	32. Registrar's Signature <i>James B. Sparks</i>							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35645

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Emma Katherine Turner				2. Date of Death Month Day Year November 7 2000		3. Time of Death 4:16 pm	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-30-8562	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 1, 1921		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10a. Street and Number 1014 Goff Road				10f. Zip Code 21221		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Barmaid / Waitress		16b. Kind of Business/Industry Tavern		
17. Father's Name (First, Middle, Last) William Frese				18. Mother's Name (First, Middle, Maiden Surname) Alice (Unk.)				
19a. Informant's Name/Relationship (Type, Print) Earnest Cessna (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1014 Goff Road, Essex, Maryland 21221				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee Michael C. Zaffron 11-00938				22. Name and Address of Facility Bruzdinski Funeral Home P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. ARRHYTHMIA Due to (or as a consequence of):								MINUTES
b. MYOCARDIAL INFARCTION Due to (or as a consequence of):								YEARS
c. ATHEROSCLEROSIS Due to (or as a consequence of):								
d.								
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Steven Mason MD				29c. License number D17347		29d. Date signed (Month, Day, Year) Nov. 8, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN MASON, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237								
31. Date filed (Month, Day, Year) NOV 08 2000				32. Registrar's Signature B. Sparks				

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State of Maryland / Department of Health and Mental Hygiene

00 35646

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) IDA VALENTINE				2. Date of Death Month October Day 30 Year 2000		3. Time of Death 7:40 pm	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center				4b. City, Town, or Location of Death Baltimore City		4c. County of Death	
Funeral Director	5. Social Security Number 217 38 2868		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) 8-21-41	
	9. Birthplace (State or Foreign Country) BALTO, Md.		10a. State Md.		10b. County BALTO.		10c. City, Town or Location BALTO.	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2313 FREDERICK AVE.		10f. Zip Code 21229		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECURITY GUARD		16b. Kind of Business/Industry PRIVATE		17. Father's Name (First, Middle, Last) FRANK VALENTINE		
18. Mother's Name (First, Middle, Maiden Surname) LOTTIE RYAN		19a. Informant's Name/Relationship (Type, Print) MICHAEL ANDERSON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3914 S. CLARE BALTO, MD 21213		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) BAYVIEW CREMATORY 11-300 BALTO, MD		20c. Location - City or Town, State BALTO, MD		21. Signature of Funeral Service Licensee Wesley Chang		22. Name and Address of Facility CHAVIS F. H. 2007 EASTERN AVE BALTO, MD 21223		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Breast Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 3 years		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Peter Good MD		
29c. License number RES 001		29d. Date signed (Month, Day, Year) October 30, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter Good Johns Hopkins Bayview Medical Center		31. Date filed (Month, Day, Year) NOV 09 2000		
32. Registrar's Signature B. Sparks		33. State Registrar NOV 09 2000		34. State Registrar NOV 09 2000		35. State Registrar NOV 09 2000		

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State of Maryland / Department of Health and Mental Hygiene

00 35647

Amended Item#17 per ABG789 11/13/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Paula Willis</i>				2. Date of Death Month <i>November</i> Day <i>3</i> Year <i>2000</i>				3. Time of Death <i>7:45 PM</i>						
	4a. Facility Name (If not institution, give street and number) <i>Future Care Canton Harbor</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death						
Funeral Director	5. Social Security Number <i>220-01-1817</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>81</i> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <i>Apr 22, 1919</i>		9. Birthplace (State or Foreign Country) <i>PA</i>		
	Usual Residence of Decedent														
10a. State <i>MD</i>		10b. County		10c. City, Town or Location <i>Baltimore</i>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number <i>1300 S. Elwood Avenue</i>				10f. Zip Code <i>21224</i>				10g. Citizen of What Country? <i>USA</i>							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>white</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i>0</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>press operator</i>				16b. Kind of Business/Industry <i>canning</i>							
17. Father's Name (First, Middle, Last) <i>(UNK) Poleski</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>unk</i>											
19a. Informant's Name/Relationship (Type, Print) <i>Angela Cambouris/daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4329 Glenmore Ave Baltimore, MD 21206</i>											
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)				Date		20c. Location - City or Town, State					
21. Signature of Funeral Service Licensee <i>Ronald S. Wade, Director</i>				22. Name and Address of Facility <i>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</i>											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Cerebrovascular Accident -</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <i>Alzheimers Dementia</i> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):														Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimers Dementia</i>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
										24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>D43725</i>				29d. Date signed (Month, Day, Year) <i>11/6/00</i>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>TARIQ MATHEWON 201-109 Buck River Neck Rd Baltimore MD 21221</i>															
State Registrar		31. Date filed (Month, Day, Year) <i>NOV 09 2000</i>		32. Registrar's Signature <i>[Signature]</i>											

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State of Maryland / Department of Health and Mental Hygiene

00 35648

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Weaver				2. Date of Death Month Day Year October 25 2000		3. Time of Death 3:25 PM	
	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice - Mercy				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-32-9543		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) August 19, 1937	
	9. Birthplace (State or Foreign Country) Ashland, KY		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 724 South Milton Avenue		10f. Zip Code 21224-3754		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Korean If Yes, Give Year or Dates: Conflict		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter		16b. Kind of Business/Industry Home and Commercial Painter				
17. Father's Name (First, Middle, Last) Lonnie Weaver				18. Mother's Name (First, Middle, Maiden Surname) Monnie Blevins				
19a. Informant's Name/Relationship (Type, Print) Barbara A. Weaver, Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 724 South Milton Ave., Baltimore, Maryland 21224-3734				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		20c. Date 10/28/2000		20d. Location - City or Town, State Towson, MD		
21. Signature of Funeral Service Licensee Jeffrey L. Gair, per DVR				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave., Dundalk, MD 21222				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		a. PNEUMONIA Due to (or as a consequence of):		b. Metastatic small cell lung cancer Due to (or as a consequence of):		c. Due to (or as a consequence of):		
		d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death 17 days 5 months		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Daniel J. Franco MD						
		29c. License number P12399		29d. Date signed (Month, Day, Year) 11/9/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL J. FRANCO UNIVERSITY OF MARYLAND 5 SOUTH GREENEST BALT. MD 21201								
31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature [Signature]						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35649

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JESTINA WEST		2. Date of Death Month November Day 4 Year 2000		3. Time of Death 3:46 pm
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore		4b. City, Town, or Location of Death Baltimore		4c. County of Death NA
Funeral Director	5. Social Security Number 216-42-2335	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) NOV 7 1943		9. Birthplace (State or Foreign Country) GA		
Usual Residence of Decedent					
10a. State MD	10b. County NA	10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 5307 CHANDLER AVE.			10f. Zip Code 21207	10g. Citizen of What Country? U S A	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: BLACK					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 4yrs.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ACCOUNTANT		16b. Kind of Business/Industry DEPT. OF HOUSING	
17. Father's Name (First, Middle, Last) SYLVESTER SHERARD			18. Mother's Name (First, Middle, Maiden Surname) ANN WINGO		
19a. Informant's Name/Relationship (Type, Print) LARRY WEST - HUSBAND			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5307 CHANDLER AVE. BALTO., MD 21207		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK		Date 11-10-00	20c. Location - City or Town, State RANDALLSTOWN, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility MARCH FUNERAL HOME WEST, INC. 4300 WABASH AVE. BALTO., MD 21215			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) Metastatic Colon Cancer					
Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis, Coagulopathy					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number RES 000		29d. Date signed (Month, Day, Year) November 8, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian L. McClure DO, 2401 West Belvedere, Baltimore, MD 21215					
31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35650

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLOTTE WALKER

2. Date of Death

Month November Day 3 Year 2000

3. Time of Death

1:45Am

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-28-9236

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

4-2-1931

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3112 Belmont Avenue

10f. Zip Code

21216

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th grade

College (1-4 or 5+)
4 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Social Security Administration

17. Father's Name (First, Middle, Last)

Lloyd Rusk

18. Mother's Name (First, Middle, Maiden Summa)

Dorothy Rodgers

19a. Informant's Name/Relationship (Type, Print)

Harold Rusk- Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1705 Ruxton Avenue Baltimore, Md 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park

Date

11-9-00

20c. Location - City or Town, State

Randallstown, Md

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

March F/H West
4300 Wabash Avenue Baltimore, Md 21215

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE INFERIOR myocardial INFARction

Due to (or as a consequence of):

b. REFRACTORY VENTRICULAR TACHYcardia

Due to (or as a consequence of):

c. Arteriosclerotic Cardiovascular DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Terance J. Lamb M.D.

29c. License number

D37203

29d. Date signed (Month, Day, Year)

November 3 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TERANCE LAMB M.D. Bon Secours Hospital, Baltimore md 21223

31. Date filed (Month, Day, Year)

NOV 09 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35651

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Agee White				2. Date of Death Month October Day 28 Year 2000				3. Time of Death 06:25 AM		
	4a. Facility Name (If not institution, give street and number) Bon Secours Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A		
Funeral Director	5. Social Security Number 237-22-6478		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 8, 1921		9. Birthplace (State or Foreign Country) North Carolina		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 Yes 2 No		
	10e. Street and Number 1733 Ashburton St.				10f. Zip Code 21216		10g. Citizen of What Country? USA				
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) 8 Elementary/Secondary (0-12) 0 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steel Worker				16b. Kind of Business/Industry Flynn + Emrich				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Elvis White				18. Mother's Name (First, Middle, Maiden Surname) Lannie Waller						
	19a. Informant's Name/Relationship (Type, Print) Mrs. Janie White (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1733 N. Ashburton St. Balto. Md. 21216						
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park		20c. Location - City or Town, State Balto. Md.						
	21. Signature of Funeral Service Licensee Joseph L. Russ		22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Respiratory Failure lung Cancer										Approximate Interval Between Onset and Death
	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown										
	24a. Was an autopsy performed? 1 Yes 2 No										
	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No										
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
	25. Was case referred to medical examiner? 1 Yes 2 No										
	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)										
	27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier Dr. [Signature]				29c. License number D0034730		29d. Date signed (Month, Day, Year) 11/3/00				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIAN B. PARKS dtd. 2000 W Baltimore St, Balt.										
	31. Date filed (Month, Day, Year) NOV 08 2000		32. Registrar's Signature [Signature]								

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35652

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Vera Ruth Warren				2. Date of Death Month Day Year November 7, 2000				3. Time of Death 6:08 pm			
	4a. Facility Name (If not institution, give street and number) Manor Care Rossville				4b. City, Town, or Location of Death Rosedale				4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 214 44 8577		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) June 25, 1920		9. Birthplace (State or Foreign Country) North Carolina			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 1613 Howard Avenue				10f. Zip Code 21221		10g. Citizen of What Country? USA					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Own Home				
	17. Father's Name (First, Middle, Last) Newton Tester				18. Mother's Name (First, Middle, Maiden Surname) Una Greene							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Harold L. Warren (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1613 Howard Avenue Baltimore, Md. 21221							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem. Gardens		Date 11/10/2000		20c. Location - City or Town, State Baltimore, Md.					
	21. Signature of Funeral Service Licensee John W. Bruckuske		MO1091		22. Name and Address of Facility Bruzdinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stroke Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death 3 Months	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, lecture, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier M. H. Sparks				29c. License number D45475		29d. Date signed (Month, Day, Year) 11/8/2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammed Rahnema M.D. 6730 Holabird Avenue Baltimore, Md. 21222												
State Registrar	31. Date filed (Month, Day, Year) NOV 08 2000				32. Registrar's Signature B. Sparks							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35653

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Norbert J. Weber				2. Date of Death Month Day Year NOVEMBER 7, 2000				3. Time of Death 11:20 A.M.	
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER				4b. City, Town, or Location of Death ROSEDALE				4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 215-22-4134		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) 01/22/1929		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 4514 Springwood Avenue				10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Postal Service Employee			16b. Kind of Business/Industry U.S Post Office		
	17. Father's Name (First, Middle, Last) Frank T. Weber				18. Mother's Name (First, Middle, Maiden Surname) Bertha Wojccik					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Rosalie L. Weber? Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4514 Springwood Avenue Baltimore, Maryland 21206					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery		Date 11/11/00		20c. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	23b. Dtd tobacco use contributes to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number DA03331		29d. Date signed (Month, Day, Year) 11/07/2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENNETH MCDOWELL, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237									
State Registrar	31. Date filed (Month, Day, Year) NOV 09 2000				32. Registrar's Signature 					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35654

AMEND ITEM: #5 PER F.H. G789 11-16-00 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANGELO PETER ZORBIS		2. Date of Death Month NOV. Day 8 Year 2000		3. Time of Death 1:10 A.M.	
	4e. Facility Name (If not institution, give street and number) 23 ODEON COURT		4b. City, Town, or Location of Death CARNEY		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 212-90-8926	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12/5/23
	9. Birthplace (State or Foreign Country) IOWA					
Usual Residence of Decedent						
10e. State MD		10b. County BALTIMORE		10c. City, Town or Location CARNEY		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 23 ODEON COURT			10f. Zip Code 21234		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH GRADE College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TAYLOR		16b. Kind of Business/Industry SELF EMPLOYED	
17. Father's Name (First, Middle, Last) PETER ZORBIS			18. Mother's Name (First, Middle, Maiden Surname) CATHERINE PLIANOS			
19a. Informant's Name/Relationship (Type, Print) TINA DIEUMEGARDE DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 ODEON COURT BALTIMORE, MD 21234			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. DEMETRIOS GREEK CEM.		20c. Location - City or Town, State 11/11/00 CARNEY, MD		
21. Signature of Funeral Service Licensee		22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
Immediate Cause (Final disease or condition resulting in death)		a. CVA				Approximate Interval Between Onset and Death months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):				
		c. Due to (or as a consequence of):				
		d. Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HTN COPD Diabetes, diet controlled						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28d. Describe how injury occurred		28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier [Signature]		29c. License number 00051926		29d. Date signed (Month, Day, Year) Nov 8, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen M Gordon 6601 N Charles St, Baltimore MD 21204						
31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature [Signature]				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35655

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Stacy Astor Adams

2. Date of Death

October 18, 2000

3. Time of Death

8:16 AM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

579-20-2889

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 23, 1921

9. Birthplace (State or Foreign Country)

Anderson, SC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Cheverly

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6339 Landover Road #203

10f. Zip Code

20785

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
7 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cab Driver

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Stacy B. Adams

18. Mother's Name (First, Middle, Maiden Surname)

Marine Clinkscales

19a. Informant's Name/Relationship (Type, Print)

Mignon Y. Harrell - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1720 Savannah St., SE #104 Washington, D.C. 20020

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Quantico National Cemetery

Date

10/23/00

20c. Location - City or Town, State

Triangle, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stewart Funeral Home, Inc.
4001 Benning Rd., NE Wash. D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. VENTRICULAR FIBRILLATION

Due to (or as a consequence of):

b. ISCHAEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

CONGESTIVE HEART FAILURE

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 47259

29d. Date signed (Month, Day, Year)

10-20-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIPISHREE NAYAK, 6501 LANDOVER ROAD, CHEVERLY MD 20785

31. Date filed (Month, Day, Year)

OCT 24 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

(3)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35656

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MATTIE REE ADAMS				2. Date of Death Month Day Year OCTOBER 22, 2000				3. Time of Death 2:00 am	
	4a. Facility Name (If not institution, give street and number) 7403 Castle Rock Drive				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 238-82-5530		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 49 Yrs.		8. Date of Birth (Month, Day, Year) April 14, 1951		9. Birthplace (State or Foreign Country) North Carolina	
	Usual Residence of Decedent				10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Clinton	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 7403 Castle Rock Drive				10f. Zip Code 20735	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) lyr	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tax Auditor				16b. Kind of Business/Industry DC Government				17. Father's Name (First, Middle, Last) Paul Vines	
	18. Mother's Name (First, Middle, Maiden Surname) Mattie Jackson				19a. Informant's Name/Relationship (Type, Print) Clinton Adams / Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7403 Castle Rock Drive Clinton, Maryland 20735	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Washington National Cemetery				20c. Location - City or Town, State Suitland, Maryland	
	21. Signature of Funeral Service Licensee Shawara L. Braxton				22. Name and Address of Facility MARSHALL'S FUNERAL HOME 4308 Suitland Road Suitland, Maryland 20746				23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Breast Cancer Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.		
29b. Signature and title of certifier Harvey I. Kotzen MD				29c. License number D20352		29d. Date signed (Month, Day, Year) 10/23/2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harvey I. Kotzen MD 8926 Woodward Rd Clinton, MD				31. Date filed (Month, Day, Year) OCT 24 2000				32. Registrar's Signature B. Sparks		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35657

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES JEFFERSON BROWN				2. Date of Death Month 10 Day 29 Year 2000		3. Time of Death 250 pm		
	4a. Facility Name (If not Institution, give street and number) HOLY CROSS HOSPITAL				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 435 84 9312		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) 4/27/44		
	9. Birthplace (State or Foreign Country) ZACHARY LOUSANA		10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2006 FORESTDALE DRIVE		10f. Zip Code 20903		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Year or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. BLACK Specify:			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SCHOOL ADMINSTRATOR		16b. Kind of Business/Industry BALTIMORE CITY PUBLIC SCHOOLS					
17. Father's Name (First, Middle, Last) CHARLES BROWN				18. Mother's Name (First, Middle, Maiden Surname) ELLA ANDERSON					
19a. Informant's Name/Relationship (Type, Print) LILLIE BROWN WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2006 FORESTDALE DRIVE, SILVER SPRING MD 20903					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATORY		Date 10/25/00		20c. Location - City or Town, State BELTSVILLE MD.			
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility 11315 LOCKWOOD DRIVE, SILVER SPRING MD. 20904							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. Sepsis Due to (or as a consequence of): b. Grown Abcess Due to (or as a consequence of): c. PANCREATITIS Due to (or as a consequence of): d. Chronic Lymphoma						Approximate Interval Between Onset and Death 2yrs			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27a. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		27b. Date of Injury (Month, Day Year)		27c. Time of Injury M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27d. Describe how injury occurred		27e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		27f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D 55213		29d. Date signed (Month, Day, Year) 10-24-2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yungsoo Pang MD 1500 Forest Glen Rd Silver Spring, MD 20910		31. Date filed (Month, Day, Year) OCT 26 2000		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

00-6047-027

BELDORA D. BOODHOO

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State of Maryland / Department of Health and Mental Hygiene

JYW

Amend #28a.Per MEO PGC 10-30-2000 cr

Certificate of Death

Reg. No.

00 35658

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Beldora Diane Boodhoo				2. Date of Death Month Day Year OCTOBER 23, 2000		3. Time of Death 03:12 A.M.	
	4a. Facility Name (If not institution, give street and number) INTERSTATE 95 south of 175				4b. City, Town, or Location of Death JESSUP		4c. County of Death HOWARD	
Funeral Director	5. Social Security Number 504-94-8908	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 44 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 7, 1956		9. Birthplace (State or Foreign Country) Guyana, S.A.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Lanham			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 5605 Haddon Place			10f. Zip Code 20706		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Analyst		16b. Kind of Business/Industry Private			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) James C. Alonzo				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Lovell			
	19a. Informant's Name/Relationship (Type, Print) Melinda Boodhoo/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5605 Haddon Dr. Lanham, Md. 20706			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		Date 10/28/00		20c. Location - City or Town, State Brentwood.MD.	
	21. Signature of Funeral Service Licensee <i>James Edwards</i>		22. Name and Address of Facility <i>Hodges & Edwards</i> 3910 Silver Hill Rd Suitland, Md. 21276					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Multiple head injuries</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 10-23-2000		28b. Time of Injury 0300 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street		28d. Describe how injury occurred Subject was driver of automobile involved in a collision					
	28f. Location (Street and Number or Rural Route Number, City or Town, State) 195 south of 175 Howard County, Maryland							
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier <i>Stephen S. Radentz, M.D.</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) OCTOBER 23, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) OCT 27 2000		32. Registrar's Signature <i>James A. Spivey</i>						

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35659

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sylvia R. Brunton				2. Date of Death Month Day Year October 22, 2000		3. Time of Death 10:27 AM	
	4a. Facility Name (If not institution, give street and number) Bowie Health Center				4b. City, Town, or Location of Death Bowie		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number None		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 15, 1918	
	9. Birthplace (State or Foreign Country) Trinidad		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Bowie	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 16300 Pointer Ridge Drive		10f. Zip Code 20716	
	10g. Citizen of What Country? Trinidad				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 0	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) David Rajnauth	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Summa) Unavailable				19a. Informant's Name/Relationship (Type, Print) Yvonne Ali Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16300 Pointer Ridge Dr. Bowie Maryland 20716	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) The Hunt Crematory		20c. Location - City or Town, State Waldorf Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Michael B. B...</i>				22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715			
	23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) Oct 22, 2000			
To Be Completed by Physician/Medical Examiner	28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Salvador Sylvester DO</i>			
	29c. License number H0055927				29d. Date signed (Month, Day, Year) October 23, 2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvador Sylvester, 3000 Hospital Drive, Chevy Chase, Maryland 20785				31. Date filed (Month, Day, Year) OCT 27 2000			
	32. Registrar's Signature <i>Bernice B. Jones</i>							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35660

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lawrence M. Breneman		2. Date of Death Month October Day 23 Year 2000		3. Time of Death 10:30 P.M.								
	4a. Facility Name (If not institution, give street and number) 2540 Davidsonville Road		4b. City, Town, or Location of Death Gambrills		4c. County of Death Anne Arundel								
Funeral Director	5. Social Security Number 164 28 1478	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 65 Yrs.	8. Date of Birth (Month, Day, Year) Jan. 6, 1935	9. Birthplace (State or Foreign Country) Pennsylvania								
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Gambrills		10d. Inside City Limits 1 Yes 2 No								
	10e. Street and Number 2540 Davidsonville Road		10f. Zip Code 21054		10g. Citizen of What Country? United States								
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: White								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) President		16b. Kind of Business/Industry Washington Savings Bank								
	17. Father's Name (First, Middle, Last) Francis E. Breneman		18. Mother's Name (First, Middle, Maiden Surname) Ann Catherine Crowley										
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Virginia Breneman Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2540 Davidsonville Rd. Gambrills Maryland 21054										
	20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial Gardens		20c. Location - City or Town, State Davidsonville MD								
	21. Signature of Funeral Service Licensee <i>Richard Bigler</i>		22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. METASTATIC CANCER TO BRAIN</td> <td>Approximate Interval Between Onset and Death 2 mos</td> </tr> <tr> <td>b. LUNG CANCER</td> <td>2 yrs</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>					Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC CANCER TO BRAIN	Approximate Interval Between Onset and Death 2 mos	b. LUNG CANCER	2 yrs	c.		d.
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC CANCER TO BRAIN	Approximate Interval Between Onset and Death 2 mos											
	b. LUNG CANCER	2 yrs											
	c.												
	d.												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown													
24a. Was an autopsy performed? 1 Yes 2 No													
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No													
25. Was case referred to medical examiner? 1 Yes 2 No													
26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)													
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined													
28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No													
28d. Describe how injury occurred													
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)													
28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier <i>[Signature]</i>													
29c. License number DOO18480													
29d. Date signed (Month, Day, Year) 10/24/00													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RONALD C. SROKA, MD 1684 VILLAGE GREEN, CROFTON, MD 21114													
31. Date filed (Month, Day, Year) OCT 27 2000													
32. Registrar's Signature <i>[Signature]</i>													

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35661

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Macarthur M. Blakely				2. Date of Death Month Day Year OCTOBER 26, 2000				3. Time of Death 3:35AM		
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital				4b. City, Town, or Location of Death Leonardtown				4c. County of Death St. Mary's		
Funeral Director	5. Social Security Number 267-12-5152		6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) 4/24/15		9. Birthplace (State or Foreign Country) Waldo, Fla.		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Charles		10c. City, Town or Location Bryans Road				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 6745 Amherst Road				10f. Zip Code 20616				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No WWII If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Attendant				16b. Kind of Business/Industry Gas Station			
17. Father's Name (First, Middle, Last) Silas A. Blakely				18. Mother's Name (First, Middle, Maiden Surname) Gertrude Unknown							
19a. Informant's Name/Relationship (Type, Print) John P. Blakely/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Bamborough Ct. Baltimore, Md. 21236							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Date 10/26/2000		20d. Location - City or Town, State Alexandria, Va.					
21. Signature of Funeral Service Licensee <i>George P. Kalas</i>				22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745							
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) a. <i>SEPSIS</i>										2 days	
Due to (or as a consequence of): b. <i>UROSEPSIS</i>										2 days.	
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. <i>HYPOTENSION</i>										1 day.	
Due to (or as a consequence of): d.											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CORONARY ARTERY DISEASE</i> <i>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</i>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>R. S. Gill</i>									
29c. License number D 56096		29d. Date signed (Month, Day, Year) 10-26-00									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. RAJBINDER S. GILL HOLLYWOOD, MD. 20636											
31. Date filed (Month, Day, Year) OCT 27 2000		32. Registrar's Signature <i>B. S. Gill</i>									

ORIGINAL

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MAISHA OLABISI BROWN				2. Date of Death Month Day Year OCTOBER 20 2000				3. Time of Death 0525						
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL				4b. City, Town, or Location of Death CHEVERLY				4c. County of Death PRINCE GEORGES						
Funeral Director	5. Social Security Number 191-08-4463		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 26 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) 11-03-73		9. Birthplace (State or Foreign Country) Montgomery, AL				
	Usual Residence of Decedent				10a. State Maryland				10b. County Prince Georges'				10c. City, Town or Location Oxon Hill		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 4545 Wheeler Road, Apt. # 613				10f. Zip Code 20745				10g. Citizen of What Country? USA							
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher				16b. Kind of Business/Industry D.C. Charter Schools							
17. Father's Name (First, Middle, Last) Ulysses Collins				18. Mother's Name (First, Middle, Maiden Surname) Rebekah Scott											
19a. Informant's Name/Relationship (Type, Print) Rebekah S. Brown/ Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 Cliffedge Road, Pikesville, MD 21208											
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery				Date 10-26-00		20c. Location - City or Town, State Clinton, Maryland					
21. Signature of Funeral Service Licensee <i>Eric D. Strickland</i>				22. Name and Address of Facility Strickland Funeral Services, P.A. 6500 Allentown Rd, Camp Springs, MD 20748											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				e. <i>Multiple Injuries</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year) 10-19-00		28b. Time of Injury 20:47M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <i>Passenger Auto - Auto Collision</i>					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>Roadway</i>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Rt 301 and St Marys Ave</i>							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) OCTOBER 21, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>David R Fowler</i>				111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) OCT 25 2000				32. Registrar's Signature <i>[Signature]</i>											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35663

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles C. Buchanan, Sr.				2. Date of Death Month Day Year October 20, 2000		3. Time of Death 3:12PM						
	4a. Facility Name (If not institution, give street and number) 10817 Tyrone Drive				4b. City, Town, or Location of Death Upper Marlboro		4c. County of Death Prince George's						
Funeral Director	5. Social Security Number 577-20-6168		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 79		8. Date of Birth (Month, Day, Year) August 21, 1921		9. Birthplace (State or Foreign Country) Washington DC				
	Usual Residence of Decedent												
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Upper Marlboro				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 10817 Tyrone Drive				10f. Zip Code 20772		10g. Citizen of What Country? U.S.A.							
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 1941- If Yes, Give Year or Dates 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Boiler Mechanic			16b. Kind of Business/Industry PEPCO						
17. Father's Name (First, Middle, Last) Cecil Cummins Buchanan					18. Mother's Name (First, Middle, Maiden Surname) Olive Elizabeth Kendrick								
19a. Informant's Name/Relationship (Type, Print) Charles C. Buchanan, Jr. (Son)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10817 Tyrone Drive Upper Marlboro, MD 20772								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery			20c. Location - City or Town, State Clinton, Maryland							
21. Signature of Funeral Service Licensee Charles L. Belanger			22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. malignant melanoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death mo			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier			29c. License number D19431		29d. Date signed (Month, Day, Year) 10/23/00					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin D. Ryan MD 11701 Livingston Rd #203, Ft. Washington, MD 20744													
31. Date filed (Month, Day, Year) OCT 25 2000			32. Registrar's Signature A. Sparks										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35664

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES

BRISKER

SR.

2. Date of Death

OCTOBER 24, 2000

3. Time of Death

9:00 p.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

6518 ADAK STREET

4b. City, Town, or Location of Death

SEAT PLEASANT

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

417-48-8973

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

12/20/31

9. Birthplace (State or Foreign Country)

MONTGOMERY, AL

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

SEAT PLEASANT

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6518 ADAK STREET

10f. Zip Code

20743

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ NoIf Yes, Give Year or Date 1/4/52
5/24/54

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (13 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PROFESSIONAL GOLFER

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

LUCY BRISKER

19a. Informant's Name/Relationship (Type, Print)

WINFORD BRISKER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6518 ADAK STREET SEAT PLEASANT, MD 20743

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CROWNSVILLE VETERANS CEMETERY

Date

10/31/2000

20c. Location - City or Town, State

CHELTENHAM, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility ALSTON FUNERAL SERVICE

5525 MARLBORO PIKE #8 FORESTVILLE, MD 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PROSTATE CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

MD 20459

29d. Date signed (Month, Day, Year)

OCTOBER 25, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANTHONY ARCENAS, M.D. VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422

State
Registrar

31. Date filed (Month, Day, Year)

OCT 26 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35665

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William L. Barnes

2. Date of Death
Month Day Year

October 19, 2000

3. Time of Death

3:30 P.M.

4a. Facility Name (If not institution, give street and number)

Montgomery Village Care & Rehabilitation Center Gaithersburg

4b. City, Town, or Location of Death

Montgomery

5. Social Security Number

579-18-1275

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

February 9, 1918

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

199 Rollins Ave.

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Retail Drug Store

17. Father's Name (First, Middle, Last)

William I. Barnes

18. Mother's Name (First, Middle, Maiden Surname)

Helen G. Boyer

19a. Informant's Name/Relationship (Type, Print)

Thomas L. Jeanrenaud-Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 1099 Locust Grove, VA 22508

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Everly Crematory October 25, 2000 Fairfax, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ft. Lincoln Funeral Home

3401 Bladensburg Rd. Brentwood, MD 20722

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

b. ATRIAL FIBRILLATION

Due to (or as a consequence of):

c. RESPIRATORY FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Attankand, M.D., Ph.D

29c. License number

D 55054

29d. Date signed (Month, Day, Year)

OCTOBER 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATTAN KASID, 17519 REDLAND ROAD, ROCKVILLE, MARYLAND

31. Date filed (Month, Day, Year)

OCT 23 2000

32. Registrar's Signature

Bruce B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1945-1946
1947-1948
1949-1950

1951-1952
1953-1954
1955-1956

1957-1958
1959-1960
1961-1962

1963-1964
1965-1966
1967-1968

1969-1970
1971-1972
1973-1974

1975-1976
1977-1978
1979-1980

1981-1982
1983-1984
1985-1986

1987-1988
1989-1990
1991-1992

1993-1994
1995-1996
1997-1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35666

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Maura Bravo		2. Date of Death Month Day Year October 19, 2000		3. Time of Death 2:13 am
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital		4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery
Funeral Director	5. Social Security Number None	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Jan. 20, 1930		9. Birthplace (State or Foreign Country) Mexico		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Hyattsville		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 2104 Ravenswood Street		10f. Zip Code 20782		10g. Citizen of What Country? Mexico
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Mexican
	14. Race - American Indian, Black, White, etc. Specify: Hispanic		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Jose Bravo		18. Mother's Name (First, Middle, Maiden Surname) Manuela Mendez		
	19a. Informant's Name/Relationship (Type, Print) Felix Vivar - Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 Ravenswood Street, Hyattsville, MD 20782		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Cemetery		20c. Location - City or Town, State Adelphi, MD
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>MYOCARDIAL INFARCTION</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier 		29c. License number 45203		29d. Date signed (Month, Day, Year) Oct. 23, 2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen M. Smith M.D. 9210 Corporate Blvd, #210, Rockville, MD 20850				
	31. Date filed (Month, Day, Year) Oct 24 2000		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35667
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John E. Brennan, Jr.

2. Date of Death

Oct. 21, 2000

3. Time of Death

12:32pm

4e. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

579-10-5327

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 26, 1918

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Delaware

10b. County

Sussex

10c. City, Town or Location

Lewes

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

39 Postal Lane

10f. Zip Code

19958

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Firefighter

16b. Kind of Business/Industry

Washington, DC

17. Father's Name (First, Middle, Last)

John Edward Brennan, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Tenley

19a. Informant's Name/Relationship (Type, Print)

Janet Edwards - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3458 Godspeed Road, Davidsonville, MD 21035

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

10/24/00

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

coronary artery disease

Due to (or as a consequence of)

b.

atrial fibrillation

Due to (or as a consequence of)

c.

aortic aneurysm

Due to (or as a consequence of)

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D28640

29d. Date signed (Month, Day, Year)

October 22, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

2414 Hightee Ct. Crofton, Md 21114

31. Date filed (Month, Day, Year)

OCT 24 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35668

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Cornelius E. Brown, Jr.

2. Date of Death

Month Day Year
Oct. 22nd. 2000

3. Time of Death

6:15a.m.

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

226 34 0072

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
8 8 1931

9. Birthplace (State or Foreign Country)

Va.

Usual Residence of Decedent

10a. State

Md.

10b. County

P.G.

10c. City, Town or Location

Chillum

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

835 Cox Ave.

10f. Zip Code

20783

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12yrs

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Educator

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Cornelius E. Brown

18. Mother's Name (First, Middle, Maiden Surname)

Grace Cooper

19a. Informant's Name/Relationship (Type, Print)

Iona Brown / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

835 Cox Ave. Chillum Md. 20783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

10/27/2000 Brentwood Md.

21. Signature of Funeral Service Licensee

#CC00273

22. Name and Address of Facility

John T. Rhines Company

3030 12th. ST., N.E. Wash., D.C. 20017

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. CARDIAC ARRHYTHMIAS

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. ATHEROSCLEROSIS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

① RECURRENT STROKES ② RECURRENT
SEPTICEMIA ③ END STAGE RENAL
DISEASE ④ SEVERE ANEMIA
⑤ METABOLIC ENCEPHALOPATHY/HYPEROSMOLAR
DISORDER ⑥ CONFUSIONAL STATE, Persistent

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident
3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mohammed A. Mannan MD

29c. License number

D 24593

29d. Date signed (Month, Day, Year)

10.23.00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOHAMMED A. MANNAN MD, 3331-TOLEDO TERRACE,
HYATTSVILLE, MD. 20782State
Registrar

31. Date filed (Month, Day, Year)

OCT 25 2000

32. Registrar's Signature

B. Spauld

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35669

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond Winfield Cleveland

2. Date of Death
Month Day Year

October 27 2000

3. Time of Death

0201

4a. Facility Name (If not institution, give street and number)

Makdon Brow Medical Center

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

220-38-1446

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 20 1942

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Suitland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4439 Rena Road #2

10f. Zip Code

20745

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1967-7013. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Stock Clerk

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

William Cleveland

18. Mother's Name (First, Middle, Maiden Surname)

Isabelle Lovinia Dennis

19a. Informant's Name/Relationship (Type, Print)

Dolly Green/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16003 Atlantic Dr. Bowie, MD. 20716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Maryland's Veterans Cem.

Date

Nov. 2

20c. Location - City or Town, State

Cheltenham, MD.

21. Signature of Funeral Service Licensee

Beha J. Jenkins

22. Name and Address of Facility

J.B. Jenkins Funeral Home
7474 Landover Rd. Landover, MD. 2078523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examination?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

26a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Salvador Sylvester, DO

29c. License number

H0055927

29d. Date signed (Month, Day, Year)

October 26, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador Sylvester, 3001 Hospital Drive, Chevy Chase, Maryland 20785

31. Date filed (Month, Day, Year)

OCT 27 2000

32. Registrar's Signature

S. Sylvester

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35670

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Teresa F. Chute				2. Date of Death Month Day Year October 23 2000				3. Time of Death 4:10 P.M.			
	4a. Facility Name (If not institution, give street and number) Crofton Convalescent Center				4b. City, Town, or Location of Death Crofton				4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 021 10 8037		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) April 30, 1909		9. Birthplace (State or Foreign Country) Massachusetts			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Crofton				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 1773 Regents Park Rd. W				10f. Zip Code 21114		10g. Citizen of What Country? United States					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give X Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telephone Operator				16b. Kind of Business/Industry New England Telephone Company			
	17. Father's Name (First, Middle, Last) William A. Geiger				18. Mother's Name (First, Middle, Maiden Surname) Lucy F. Webel							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Kenneth F. Chute Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1773 Regents Park Rd. W Crofton Maryland 21114							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial Gardens				Date October 26, 2000		20c. Location - City or Town, State Davidsonville MD			
	21. Signature of Funeral Service Licensee Michael L. B. Fisher				22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715							
	23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): b. DEHYDRATION Due to (or as a consequence of): c. HYPERTENSION Due to (or as a consequence of): d. ALCOHOLIC LIVER DISEASE										Approximate Interval Between Onset and Death 48 HRS 72 HRS 7+ YEARS 7+ YEARS	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
State Registrar	29b. Signature and title of certifier [Signature]				29c. License number D0018480				29d. Date signed (Month, Day, Year) 10/24/00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RONALD C. SROKA, M.D. 1684 VILLAGE GREEN, CROFTON, MD. 21114											
31. Date filed (Month, Day, Year) OCT 27 2000		32. Registrar's Signature [Signature]										

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35671

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

CATHERINE L. CLARK

2. Date of Death

Month Day Year
10 23 2000

3. Time of Death

12:45am

4e. Facility Name (If not institution, give street and number)

5812 LUNDY DRIVE

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGES

5. Social Security Number

239-84-3250

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

12-26-49

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MD.

10b. County

Prince Georges

10c. City, Town or Location

LANHAM

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5812 Lundy Drive

10f. Zip Code

20706

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

RESOURCE SPECIALIST

16b. Kind of Business/Industry

USDA

17. Father's Name (First, Middle, Last)

NATHANIEL NIXON

18. Mother's Name (First, Middle, Maiden Surname)

CATHERINE SMITH

19a. Informant's Name/Relationship (Type, Print)

Lawrence Clark

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5812 LUNDY DR., LANHAM MD. 20706

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HARMONY Cemetery

Date

10/26/00

20c. Location - City or Town, State

LANDOVER, MD.

21. Signature of Funeral Service Licensee

Lisa A. Henry 401178

22. Name and Address of Facility

B.K. HENRY FUNERAL CHAPEL
420 H ST. N.E., WASH. D.C. 20002

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BREAST CANCER

Approximate Interval Between Onset and Death

11 yrs

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen P. Stahl MD

29c. License number

D18219

29d. Date signed (Month, Day, Year)

10/24/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEPHEN STAAL 1221 MERCANTILE LAKE LAROO MD 20774

31. Date filed (Month, Day, Year)

OCT 26 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Deborah Marie Chevalier

amend item 23a,27,28a,b,c,d,e,f per me G789 11/16/00 y

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35672

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Deborah Marie Chevalier				2. Date of Death Month Day Year October 31, 2000				3. Time of Death 11:20 A.M.			
	4a. Facility Name (If not institution, give street and number) 10200 Prince Place, Apartment T6				4b. City, Town, or Location of Death Largo				4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 217-72-4323		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 43 Yrs.		8. Date of Birth (Month, Day, Year) 04-08-1957		9. Birthplace (State or Foreign Country) Washington, DC			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD		10b. County Prince George's		10c. City, Town or Location Upper Marlboro				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 10200 Prince Place, Apt. T6				10f. Zip Code 20774		10g. Citizen of What Country? U.S.A.					
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant				16b. Kind of Business/Industry Private			
	17. Father's Name (First, Middle, Last) Harry Chevalier				18. Mother's Name (First, Middle, Maiden Surname) Christine King							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Antonio Chevalier/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10214 North Riva Ridge Loop Ft. Drum, NY 13602							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Riverdale Crematory		Date 11/4/2000		20c. Location - City or Town, State Riverdale, MD					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd., Landover, MD 20785							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene									
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) found: 10/31/00		28b. Time of Injury found: 11:20 A		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unknown			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found: residence				28f. Location (Street and Number or Rural Route Number, City or Town, State) 10200 Prince Place T6 Largo, Maryland							
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
State Registrar	29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) November 01, 2000					
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARY G. RIPPKE, M.D. 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) NOV 03 2000		32. Registrar's Signature 										

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35673

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUTH GILES COLEMAN			2. Date of Death Month Day Year OCT 18, 2000		3. Time of Death 23:15		
	4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL			4b. City, Town, or Location of Death CLINTON		4c. County of Death PRINCE GEORGES		
Funeral Director	5. Social Security Number 578-48-7711		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) 8-25-29	
	9. Birthplace (State or Foreign Country) WASHINGTON DC		10a. State DC		10b. County WASHINGTON DC		10c. City, Town or Location WASHINGTON DC	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 317 18th ST S.E.		10f. Zip Code 20003		10g. Citizen of What Country? UNITED STATES		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CUSTODIAL		16b. Kind of Business/Industry FED GOVT				
17. Father's Name (First, Middle, Last) EVERETT W. GILES		18. Mother's Name (First, Middle, Maiden Surname) RUTH MATTHEWS						
19a. Informant's Name/Relationship (Type, Print) MARNETTE RICE / DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4011 HOPPIN LANE, SUITLAND, MD 20746						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HARMONY MEMORIAL CEMETERY 10-27-00 LANDOVER, MD		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee Alex S. Pope Jr.		22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOME 2617 PENN. AVE S.E. WASHINGTON DC 20020						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary EDEMA Due to (or as a consequence of): b. CORONARY ARTERY DISEASE, RECENT MI Due to (or as a consequence of): c. RENAL FAILURE Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARDIAC ARRHYTHMIA S/P AICD PLACEMENT SLEEP APNEA.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28c. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Hawani Temesgen MD		29c. License number D46576		29d. Date signed (Month, Day, Year) 10/20/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAWANI TEMESGEN, 6104 OLD BRANCH AVE, TEMPLE HILLS, MD, 20748		31. Date filed (Month, Day, Year) OCT 23 2000		32. Registrar's Signature [Signature]				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35674

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothea O'Neill Carter

2. Date of Death

Month Day Year

10/20/00

3. Time of Death

7:30 pm

4a. Facility Name (If not institution, give street and number)

VILLA ROSA HOME

4b. City, Town, or Location of Death

MITCHELLVILLE

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

218-07-5734

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 16, 1914

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

VIRGINIA

10b. County

FAIRFAX

10c. City, Town or Location

ALEXANDRIA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1210 BURTONWOOD COURT

10f. Zip Code

22307

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

JAMES G. O'NEILL

18. Mother's Name (First, Middle, Maiden Surname)

HELEN A. REILLY

19a. Informant's Name/Relationship (Type, Print)

THOMAS C. CARTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1210 BURTONWOOD COURT ALEXANDRIA, VA 22307

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON NATIONAL

Date

10/31/00 ARLINGTON, VA

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DEMAINE FUNERAL HOME
520 S. WASHINGTON STREET ALEXANDRIA, VA 22314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

9500 Alexandria Rd, CA 90000

31. Date filed (Month, Day, Year)

OCT 23 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35675

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charlotte Thomas Comstock		2. Date of Death Month October Day 19 Year 2000		3. Time of Death 9:00 PM
	4a. Facility Name (If not institution, give street and number) 3904 Parsons Lane		4b. City, Town, or Location of Death Chevy Chase		4c. County of Death Montgomery
Funeral Director	5. Social Security Number 253-46-4391	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Sept. 22, 1908		9. Birthplace (State or Foreign Country) New York		
Usual Residence of Decedent					
10a. State Md.		10b. County Montgomery		10c. City, Town or Location Chevy Chase	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 3904 Parsons Lane			10f. Zip Code 20815		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own home	
17. Father's Name (First, Middle, Last) Walter E. Thomas			18. Mother's Name (First, Middle, Maiden Surname) Martha vonKleist		
19a. Informant's Name/Relationship (Type, Print) SON Edmund T. Comstock III			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3904 Parsons Lane, Chevy Chase, Md. 20815		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria, VA.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
a. Congestive heart failure		years			
Due to (or as a consequence of):					
b. Atrial fibrillation		years			
Due to (or as a consequence of):					
c. Hypertensive cardiovascular disease		years			
Due to (or as a consequence of):					
d. 					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
Status post cerebral vascular accident					
feeding gastrostomy tube					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D35579		29d. Date signed (Month, Day, Year) Oct. 20, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan J. Miller MD, 6844 Tulip Hill Terrace, Bethesda, Md. 20816					
31. Date filed (Month, Day, Year) OCT 23 2000		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35676

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THERMAN L. COOPER

2. Date of Death

Month Day Year
October 23, 2000

3. Time of Death

1540

4a. Facility Name (If not institution, give street and number)

1139 Southview Apartment #303

4b. City, Town, or Location of Death

Oxon Hill

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

243-52-9066

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)

June 16, 1931

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Oxon Hill

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1139 Southview Drive #303

10f. Zip Code

20745

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Press Operator

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

George Cooper

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Alston

19a. Informant's Name/Relationship (Type, Print)

Pamela Mason / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9915 Williamsburg Drive Upper Marlboro, MD 20772

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

10-30-00 Brentwood, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Shawanda Braxton

22. Name and Address of Facility

Marshall's Funeral Home

4308 Suiland Road Suitland, Maryland 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Arteriosclerotic Cardiovascular Disease*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?
☒ Yes ☐ No

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home

☒ Residence

☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Salvador E. Luster, DO

29c. License number

1H0055927

29d. Date signed (Month, Day, Year)

October 23, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador E. Luster, 2001 Hospital Drive, Cheverly, Maryland 20785

31. Date filed (Month, Day, Year)

OCT 24 2000

32. Registrar's Signature

Shawanda Braxton

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35677

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LESTROY BROOKS CARTER

2. Date of Death

Month Day Year
OCT. 21, 2000

3. Time of Death

11:45 AM

4a. Facility Name (If not institution, give street and number)

5525 HILL WAY

4b. City, Town, or Location of Death

CAMP SPRINGS

4c. County of Death

PRINCE GEORGE

Funeral
Director

5. Social Security Number

251-76-8352

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

55

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 11, 1945

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE

10c. City, Town or Location

CAMP SPRINGS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5525 HILL WAY

10f. Zip Code

20746

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MANAGER

16b. Kind of Business/Industry

AT&T

17. Father's Name (First, Middle, Last)

GEORGE WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname)

MARGIE BARNES

19a. Informant's Name/Relationship (Type, Print)

DAVID J. CARTER-HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5525 HILL WAY CAMP SPRINGS, MD 20746

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OLIVE GROVE CHURCH CEMTERY 10/28 COWARD, SC

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Theodore C. Pinckney

22. Name and Address of Facility

PINCKNEY-SPANGLER FUNERAL HOME
524 - 8TH ST., N. E. WASH., DC 20002

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. PULMONARY FIBROSIS

Due to (or as a consequence of):

c. RHMATOID ARTHRITIS

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edgar V. Potter, Jr.

29c. License number

009565

29d. Date signed (Month, Day, Year)

OCTOBER 23, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDGER V. POTTER, JR. M. D. 1328 SOUTHERN AVE., S. E. SUITE 210 WASH., DC 20032

31. Date Filed (Month, Day, Year)

OCT 24 2000

32. Registrar's Signature

Benita L. Spaulding

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35678

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roscoe Duncan		2. Date of Death Month Day Year October 24 2000		3. Time of Death 12:45p.m.						
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital		4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's						
Funeral Director	5. Social Security Number 251-12-8498	6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.						
	8. Date of Birth (Month, Day, Year) Nov. 23, 1903		9. Birthplace (State or Foreign Country) South Carolina								
Usual Residence of Decedent											
10a. State MD		10b. County Prince George's		10c. City, Town or Location Capitol Heights							
10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No											
10e. Street and Number 6422 L Street			10f. Zip Code 20743		10g. Citizen of What Country? U.S.A.						
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:							
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)									
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer		16b. Kind of Business/Industry Private									
17. Father's Name (First, Middle, Last) Jack Duncan			18. Mother's Name (First, Middle, Maiden Surname) Mary Jane McNeal								
19a. Informant's Name/Relationship (Type, Print) Pearl Cowan Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6422 L Street Capitol Heights, MD. 20743								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Location - City or Town, State 10/31/00 Landover, MD							
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD. 20785									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a. <i>Respiratory failure.</i></td> <td rowspan="4"> Approximate Interval Between Onset and Death <i>< one-hour</i> </td> </tr> <tr> <td>b. <i>Lower Gastrointestinal Bleeding</i></td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <i>Respiratory failure.</i>	Approximate Interval Between Onset and Death <i>< one-hour</i>	b. <i>Lower Gastrointestinal Bleeding</i>	c.	d.
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <i>Respiratory failure.</i>	Approximate Interval Between Onset and Death <i>< one-hour</i>									
	b. <i>Lower Gastrointestinal Bleeding</i>										
	c.										
	d.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Right knee decubal ulcer.</i> <i>Advanced age.</i>											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M							
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred									
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D-34525		29d. Date signed (Month, Day, Year) 10-25-00							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.J. Rao, 4000 Mitchellville Road, #220, Bowie-20716 (MD)											
31. Date filed (Month, Day, Year) OCT 27 2000		32. Registrar's Signature <i>[Signature]</i>									

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35679

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LUCY M. DAVENPORT		2. Date of Death Month Day Year OCTOBER 24 2000		3. Time of Death 5:30 AM
	4a. Facility Name (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL		4b. City, Town, or Location of Death LANHAM		4c. County of Death PRINCE GEORGES
Funeral Director	5. Social Security Number 237-10-0055	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) APRIL 5, 1907		9. Birthplace (State or Foreign Country) S.C.		
Usual Residence of Decedent					
10e. State DC		10b. County WASHINGTON		10c. City, Town or Location WASHINGTON	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 409 E STREET, SE #202		10f. Zip Code 20003	
10g. Citizen of What Country? U.S.A.		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC		16b. Kind of Business/Industry U.S. CAPITOL		17. Father's Name (First, Middle, Last) UNKNOWN	
18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN		19a. Informant's Name/Relationship (Type, Print) FRANK STEVENSON - NEPHEW		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1275 OWEN PLACE, NE WASHINGTON, DC 20002	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		20c. Location - City or Town, State 11/4/00 Washington, D.C.	
21. Signature of Funeral Service Licensee B. E. Taylor		22. Name and Address of Facility TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH. DC 20001			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 7 years Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Paul A. DeVore MD		29c. License number 201852		29d. Date signed (Month, Day, Year) OCTOBER 24, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL A. DEVORE MD 4203 QUEENSBURY RD HYATTSVILLE MD 20781					
31. Date filed (Month, Day, Year) OCT 27 2000		32. Registrar's Signature Paul A. DeVore			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35680

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Willis Doctor				2. Date of Death Month Day Year October 24, 2000				3. Time of Death 2:40 A.M.	
	4a. Facility Name (If not institution, give street and number) 9304 Cheltenham Drive				4b. City, Town, or Location of Death Brandywine				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 248 58 8845		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) June 28, 1940		9. Birthplace (State or Foreign Country) South Carolina	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Brandywine				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 9304 Cheltenham Drive				10f. Zip Code 20613		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Operator			16b. Kind of Business/Industry Metro		
	17. Father's Name (First, Middle, Last) Willie Doctor				18. Mother's Name (First, Middle, Maiden Surname) Eloise Haigood					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Patricia Doctor (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9304 Cheltenham Drive, Brandywine, Maryland 20613					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery				20c. Location - City or Town, State Clinton, Maryland			
	21. Signature of Funeral Service Licensee ► <i>St. G. Sitt</i>				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. acute myocardial infarction</i> Due to (or as a consequence of): <i>b. Coronary artery Disease</i> Due to (or as a consequence of): <i>c.</i> Due to (or as a consequence of): <i>d.</i>									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined									
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	28d. Describe how injury occurred									
	28e. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <i>Shemar Luck</i>				29c. License number D13231		29d. Date signed (Month, Day, Year) 10-25-00			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9470 Annapolis Rd Lasham, Md 20706									
	31. Date filed (Month, Day, Year) OCT 27 2000				32. Registrar's Signature <i>James B. Smith</i>					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35681

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John R. Delmore				2. Date of Death Month Day Year October 22, 2000				3. Time of Death 3:40 PM	
	4a. Facility Name (If not institution, give street and number) 8611 Vistula Drive				4b. City, Town, or Location of Death Ft. Washington				4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 101-12-7531		6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>		7. Age (In yrs. last birthday) Yrs. 79		8. Date of Birth (Month, Day, Year) 02-10-1921		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Ft. Washington				10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 8611 Vistula Drive				10f. Zip Code 20744		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1974		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 5		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) Pilot				16b. Kind of Business/Industry Military			
	17. Father's Name (First, Middle, Last) Francis A. Delmore				18. Mother's Name (First, Middle, Maiden Surname) Mary Russell					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Yvonne Delmore Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8611 Vistula Drive Ft. Washington, MD 20744					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Pinelawn National Cemetery		20c. Date October 26, 2000		20d. Location - City or Town, State Babylon NY			
	21. Signature of Funeral Service Licensee <i>George P. Kalas</i>				22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Road Oxon Hill, Maryland 20745					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Non-Hodgkins NHL</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Lymphocytic Leukemia</i>									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier <i>Robert Donegan</i>				29c. License number MD 057546-L (PA)				29d. Date signed (Month, Day, Year) 10/24/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Donegan, MD 1050 Q. Perimeter Rd. #BB-50 Andrews AFB, MD 20762									
31. Date filed (Month, Day, Year) OCT 24 2000										
32. Registrar's Signature <i>Barbara B. Sparks</i>										

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35682

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Elizabeth Duplisse				2. Date of Death Month Day Year October 22, 2000		3. Time of Death 4:40 pm	
	4a. Facility Name (If not institution, give street and number) 8815 Frederick Avenue				4b. City, Town, or Location of Death North Beach		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 579-24-2597	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 29, 1925		9. Birthplace (State or Foreign Country) Washington, DC
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Calvert		10c. City, Town or Location North Beach		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 8815 Frederick Avenue				10f. Zip Code 20714		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Secretary		16b. Kind of Business/Industry Federal Government			
	17. Father's Name (First, Middle, Last) Erich Dominic Planer				18. Mother's Name (First, Middle, Maiden Surname) Jane Gilbane			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Anna M. O'Donnoghue - Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13736 Hillside Avenue, Thurmont, MD 21788			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Date 10/26/00		20c. Location - City or Town, State Brentwood, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781			
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Lung Carcinoma with Metastasis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
State Registrar	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number A39920		29d. Date signed (Month, Day, Year) October 23, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Michael Brooks, M.D., 110 Hospital Drive, III, Prince Frederick, MD 20678								
31. Date filed (Month, Day, Year) OCT 24 2000				32. Registrar's Signature 				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35683

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gwendolyn B. Felton				2. Date of Death Month Day Year October 15, 2000				3. Time of Death 222 am	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 296-30-3630		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) June 30, 1934		9. Birthplace (State or Foreign Country) North Carolina	
	Usual Residence of Decedent 10a. State: Maryland 10b. County: Prince Georges 10c. City, Town or Location: Largo 10d. Inside City Limits: 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 1200 Falconett Court 10f. Zip Code: 20774 10g. Citizen of What Country? U.S.A.					
To Be Completed by Funeral Director	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher				16b. Kind of Business/Industry Education			
	17. Father's Name (First, Middle, Last) David C. Blue				18. Mother's Name (First, Middle, Maiden Surname) Bertha Nivens					
	19a. Informant's Name/Relationship (Type, Print) Valeri Gamble / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 Falconett Ct. Largo, MD 20774					
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		Date October 23, 2000		20c. Location - City or Town, State Brentwood, MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Pulmonary Thromboembolism</u> Due to (or as a consequence of): b. <u>Deep Vein Thromboses</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier 				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) October 16, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) OCT 23 2000 32. Registrar's Signature 										

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35684

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Louis Giersch

2. Date of Death

Month

Day

Year

10-23-2000

3. Time of Death

10:03 AM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST NURSING CENTER-ROCKVILLE

4b. City, Town, or Location of Death

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

579-14-1345

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

NOV. 24, 1915

9. Birthplace (State or Foreign Country)

COLORADO

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9701- MEDICAL CENTER DRIVE

10f. Zip Code

20850

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

POLICEMAN

16b. Kind of Business/Industry

D.C. MET. POLICE

17. Father's Name (First, Middle, Last)

THEODORE GIERSCH

18. Mother's Name (First, Middle, Maiden Surname)

ANNA SCHEIDT

19a. Informant's Name/Relationship (Type, Print)

GORDON GIERSCH- son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1523- E. HILLSBORO BLVD., #735 DEERFIELD BEACH, FLA.

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METROPOLITAN CREMATORY-10/25-ALEXANDRIA, VA.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

W. M. Hyson

22. Name and Address of Facility

HYSON CO., INC.

6510- 16th ST., NW, WASH., DC

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Due to (or as a consequence of):

Chronic myelogenous Leukemia

Due to (or as a consequence of):

Emphysema

Due to (or as a consequence of):

Diabetes Mellitus

Approximate Interval Between Onset and Death

DAYS

YRS

YRS

YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. G. Rao

29c. License number

D35792

29d. Date signed (Month, Day, Year)

OCTOBER, 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. G. Rao, 50, W. Edmonston Dr, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year)

OCT 26 2000

32. Registrar's Signature

S. G. Rao

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 35685

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wilma G. Gross				2. Date of Death Month Day Year Oct. 23 2000				3. Time of Death 9:58 P.M.					
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel					
Funeral Director	5. Social Security Number 315 62 2433		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) June 9, 1913		9. Birthplace (State or Foreign Country) Indiana	
	Usual Residence of Decedent													
10a. State Indiana		10b. County Kosciusko		10c. City, Town or Location Warsaw				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
10e. Street and Number 4455 North 375 E.				10f. Zip Code 46580				10g. Citizen of What Country? United States						
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home						
17. Fether's Name (First, Middle, Last) Jesse Norman				18. Mother's Name (First, Middle, Maiden Surname) Judel Alspach										
19a. Informant's Name/Relationship (Type, Print) Peter W. Gross Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 767 E. 250 N. Warsaw Indiana 46582										
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Oakwood Cemetery				20c. Location - City or Town, State Warsaw Indiana						
21. Signature of Funeral Service Licensee <i>Michael L. Byche</i>				22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715										
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute myocardial infarction Due to (or as a consequence of): b. Coronary artery disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):												Approximate Interval Between Onset and Death minutes years		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.														
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown														
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. Signature and title of certifier <i>James W. Ross MD</i>				29c. License number D0023148				29d. Date signed (Month, Day, Year) 10/24/2000						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James W. Ross MD, 4176 N. Hanson Ct., Bowie, MD 20716														
31. Date filed (Month, Day, Year) OCT 27 2000				32. Registrar's Signature <i>Benjamin A. Sparks</i>										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 2008.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35686

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Cecilia G. Griffith

2. Date of Death

Oct 21 2000

3. Time of Death

1:55 pm

4a. Facility Name (If not institution, give street and number)

Calvert Manor Healthcare Center

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

579-62-9565

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

July 1, 1906

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil
345 Fell Road

10c. City, Town or Location

Rising Sun

10f. Zip Code

21911

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (14 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

F.X. Auth

18. Mother's Name (First, Middle, Maiden Surname)

Mary Kathryn Koppers

19a. Informant's Name/Relationship (Type, Print)

Theresa C. Schmidt (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

345 Fell Road Rising Sun, Maryland 21911

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

October 24, 2000

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

Louis L. Grant

22. Name and Address of Facility

Lee Funeral Home, Inc.
6633 Old Alexandria Ferry Road Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Edema

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ASCVD

Due to (or as a consequence of):

3 yrs

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul R. Taylor MD

29c. License number

0-11115

29d. Date signed (Month, Day, Year)

10-21-00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Calvert Healthcare Center, Rising Sun, MD 21911

31. Date filed (Month, Day, Year)

OCT 25 2000

32. Registrar's Signature

Beverly A. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35687

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Edward Gates				2. Date of Death Month Day Year October 19, 2000		3. Time of Death 9:42 A.M.	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 258-68-8484		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 14, 1947	9. Birthplace (State or Foreign Country) Georgia
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Temple Hills		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 4611 Brinkley Road				10f. Zip Code 20748		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 year College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Drug Counselor		16b. Kind of Business/Industry Kobra Rehabilitation Program	
	17. Father's Name (First, Middle, Last) Joseph Edward Gates				18. Mother's Name (First, Middle, Maiden Surname) Geneva McCall			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Barbara Ann Brooks Gates (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4611 Brinkley Road; Temple Hills, Maryland 20748			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery/Oct. 25, 2000		20c. Location - City or Town, State Suitland, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, DC. 20011			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis b. Pneumonia c. HIV / AIDS d. 							Approximate Interval Between Onset and Death 24 hrs 1-2 days
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.				29c. License number D56181		29d. Date signed (Month, Day, Year) October 19, 2000		
29b. Signature and title of certifier 				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul M. Regan 7503 Surratts Road, Clinton, MD 20735				
31. Date filed (Month, Day, Year) OCT 25 2000		32. Registrar's Signature 						

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35688

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marie Lange Geiger				2. Date of Death Month Day Year October 04, 2000				3. Time of Death 4:33am	
	4a. Facility Name (If not institution, give street and number) Potomac Valley Nursing Home				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577090343		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 26, 1908		9. Birthplace (State or Foreign Country) Minnesota	
	Usual Residence of Decedent				10a. State MD		10b. County Montgomery		10c. City, Town or Location Bethesda	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 4803 Dover Rd				10f. Zip Code 20816	
	10g. Citizen of What Country? USA				11. Mental Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary/Homemaker				16b. Kind of Business/Industry US Government				17. Father's Name (First, Middle, Last) Herman J. Lange	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Julianne Melland				19a. Informant's Name/Relationship (Type, Print) Robert E. Geiger/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3856 Philip Ludwell, Williamsburg, VA, 23188	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National				20c. Location - City or Town, State 101900 Arlington, VA	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee W. Off Muncy				22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisc. Ave, NW, Washington, DC 20016				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. cancer of colon Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. 15 yrs	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Walter Gooch MD				29c. License number DO1120	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) OCT 18, 2000				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) WALTER GOOCH MD 1299 LAMBERTON DRIVE WHEATON MD 20902				31. Date filed (Month, Day, Year) OCT 23 2000	
	32. Registrar's Signature James B. Sparks				33. Registrar's Signature James B. Sparks				34. Registrar's Signature James B. Sparks	

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 35689

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

John Raymond Greenleaf

2. Date of Death

Month Day Year
October 16, 2000

3. Time of Death

5:30am

4a. Facility Name (If not institution, give street and number)

9417 Duxford Ct

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

5. Social Security Number

193146259

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 11, 1923

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9417 Duxford Ct

10f. Zip Code

20854

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Unknown

16b. Kind of Business/Industry

N.S.A.

17. Father's Name (First, Middle, Last)

Albert Hatfield Greenleaf

18. Mother's Name (First, Middle, Maiden Surname)

Mary Stewart

19a. Informant's Name/Relationship (Type, Print)

Marjorie Greenleaf/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9417 Duxford Ct., Potomac, MD 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rock Creek Cemetery

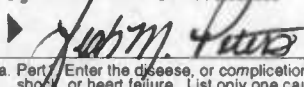
Date

101900

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Joseph Gawler's Sons
5130 Wisconsin Ave, NW, Washington, DC 2001623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 years

b. Cardiomyopathy

Due to (or as a consequence of):

5 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

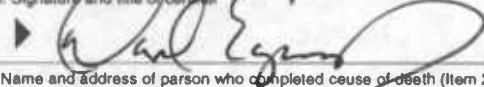
28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier



29c. License number

D23783

29d. Date signed (Month, Day, Year)

October 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Esposito, MD, 5530 Wisconsin Ave, #1400, Chevy Chase, MD 20815

31. Date filed (Month, Day, Year)

OCT 23 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35690

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BENJAMIN C. GOODE

2. Date of Death

OCTOBER 18, 2000

3. Time of Death

11:30am

4a. Facility Name (If not institution, give street and number)

3406 Cohasset Ave.

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

291-05-5583

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Mar. 15, 1915

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3406 Cohasset Avenue

10f. Zip Code

21403

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married

☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Foreign Service Officer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Benjamin J. Goode

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Jean Jones

19a. Informant's Name/Relationship (Type, Print)

Sally B. Goode/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3406 Cohasset Ave, Annapolis, Md. 21403

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rock Creek Cemetery

Date

10.20.00

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

Belra J. Jenkins

22. Name and Address of Facility

Johnson & Jenkins Inc.

716 Kennedy St., N.W. Wash. D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC PROSTATE CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Pending investigation

☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Howard Goldstein

29c. License number

D26743

29d. Date signed (Month, Day, Year)

October 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard Goldstein, Md. 205 Ridgely Ave, Annapolis, Md. 21401

31. Date filed (Month, Day, Year)

OCT 24 2000

32. Registrar's Signature

Bruce A. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35691

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rose F. Gordon				2. Date of Death Month Day Year Oct. 20, 2000		3. Time of Death 10:12am	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 578-24-5845		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 26, 1922	9. Birthplace (State or Foreign Country) Ft. Lawn, S.C.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Capital Heights		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 6703 Calmos Street				10f. Zip Code 20743		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Beautician		16b. Kind of Business/Industry Private			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Jay Edwards				18. Mother's Name (First, Middle, Maiden Surname) Janie Brace			
	19a. Informant's Name/Relationship (Type, Print) Melrod Lynn / Nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 243 Ft. Lawn, S.C. 29714			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lawn Cemetery		Date 10/28/00		20c. Location - City or Town, State Ft. Lawn, S.C.	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747			
Physician /Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Embolism Due to (or as a consequence of): b. Thromboembolic phenomenon Due to (or as a consequence of): c. Carcinoma of the colon, far advanced with Due to (or as a consequence of): d. pelvic carcinomatosis							Approximate Interval Between Onset and Death 1 day 1 day 2-3 mos
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Diabetes mellitus Hypertension							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D0015513 (MD)		29d. Date signed (Month, Day, Year) 10/22/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUCIO S. VILLA-REAL, MD - #10 ST. PATRICKS DRIVE SUITE 502, WILDORE, MD. 20603								
31. Date filed (Month, Day, Year) OCT 24 2000		32. Registrar's Signature <i>[Signature]</i>						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35692

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Martha E. Gunter

2. Date of Death

10 - 22-2000

3. Time of Death

10:05pm

4a. Facility Name (If not institution, give street and number)

Hillhaven Nursing Center

4b. City, Town, or Location of Death

Adelphi

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

220-03-7084

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan. 4, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6002 Westchester Park Dr., #301

10f. Zip Code

20740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Prince George's Co.

Board of Education

17. Father's Name (First, Middle, Last)

Thomas McGuire

18. Mother's Name (First, Middle, Maiden Surname)

Wilhamina Eichhorn

19a. Informant's Name/Relationship (Type, Print)

Linda G. Koennel - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6314 Naval Avenue, Lanham, MD 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Frostburg Memorial Park

Date

10/27/00

20c. Location - City or Town, State

Frostburg, Maryland

21. Signature of Funeral Service licensee

Henry J. Ford

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ATHEROSCLEROSIS

Approximate Interval Between Onset and Death

15 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMER'S DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles W. Bunker

29c. License number

D31563

29d. Date signed (Month, Day, Year)

October 23, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES BUNKER MD, 11251 LOCKWOOD DRIVE, SILVER SPRING, MD 20901

State
Registrar

31. Date filed (Month, Day, Year)

OCT 24 2000

32. Registrar's Signature

A. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35693

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Florence V.. Greene				2. Date of Death Month Day Year Oct. 19th 2000				3. Time of Death 1:20p.m.		
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 579 24 4674		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) May 27 1926		9. Birthplace (State or Foreign Country) Md.		
	Usual Residence of Decedent				10a. State DC				10b. County Washington, D.C.		
10c. City, Town or Location				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 1421 Crittenden Street, N.W.			
10f. Zip Code 20011				10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			
12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12yrs.				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Librarian				16b. Kind of Business/Industry Private			
17. Father's Name (First, Middle, Last) Bernard Flood				18. Mother's Name (First, Middle, Maiden Surname) Hattie B. Thomas				19a. Informant's Name/Relationship (Type, Print) James F. Greene, Sr / Husband			
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1421 Crittenden St., N.W. Wash., DC.. 20011				20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery			
20c. Date 10/25/2000				20d. Location - City or Town, State Brentwood Md.				21. Signature of Funeral Service Licensee #CC00273			
22. Name and Address of Facility John T. Rhines Company 3030 12th ST., N.E. Wash., D.C. 20017				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 2 days 2 weeks 6 weeks			
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Were an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M			
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Dr A MENDHIRATTA MD			
29c. License number D38262				29d. Date signed (Month, Day, Year) October 19, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr A MENDHIRATTA 2401 Research Blvd Suite 340 MD 20854			
31. Date filed (Month, Day, Year) OCT 25 2000				32. Registrar's Signature [Signature]				33. Registrar's Title [Signature]			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35694

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHRISTOPHER HILL				2. Date of Death Month Day Year October 20, 2000		3. Time of Death 5:00 AM	
	4a. Facility Name (If not institution, give street and number) 13835 Beacon Hollow				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579-48-6186	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 12, 1934		9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery		10c. City, Town or Location Silver Spring		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 13835 Beacon Hollow			10f. Zip Code 20906		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 yrs		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry U.S. Navy Dept.			
	17. Father's Name (First, Middle, Last) Authur Hill				18. Mother's Name (First, Middle, Maiden Surname) Ruby Williams			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Rene Hill - Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13835 Beacon Hollow, Silver Spring MD 20906				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Cemetery		Date 10-26-00		20c. Location - City or Town, State Wheaton, Maryland	
	21. Signature of Funeral Service Licensee Julia P. Marshall			22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington DC 20011				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cancer of the Pancreas Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death 10 months
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier E. P. Libie MD				29c. License number D09470		29d. Date signed (Month, Day, Year) 10/20/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene P. Libie, M.D. 10400 Connecticut Ave., Kensington MD 20895								
31. Date filed (Month, Day, Year) OCT 26 2000		32. Registrar's Signature Beyonce B. Spade						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35695

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Irma H. Hawkins		2. Date of Death Month October Day 23 Year 2000		3. Time of Death 9:15 A.M.
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A
Funeral Director	5. Social Security Number 577 48 1553	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) June 17, 1928		9. Birthplace (State or Foreign Country) Germany		
Usual Residence of Decedent					
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Mitchellville	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2731 Woodlake Road		10f. Zip Code 20716	
10g. Citizen of What Country? United States		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner		16b. Kind of Business/Industry Franks Garden Center		17. Father's Name (First, Middle, Last) Karl Willems	
18. Mother's Name (First, Middle, Maiden Surname) Anna (Unavailable)		19a. Informant's Name/Relationship (Type, Print) Robert Hawkins Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5407 Bradley Blvd. Bethesda Maryland 20814	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Gardens		20c. Location - City or Town, State Annapolis Maryland	
21. Signature of Funeral Service Licensee Michael L. Byler		22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715			
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) sepsis Due to (or as a consequence of): pancreatic carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acute renal failure Hepatic failure		Approximate Interval Between Onset and Death 72 hours 6 months			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute renal failure Hepatic failure		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Dr. Geoffrey Nguyen MD	
29c. License number RES-000		29d. Date signed (Month, Day, Year) October 23, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Nguyen; Johns Hopkins Hospital; 600 N. Wolfe St., Baltimore, MD 21287	
31. Date filed (Month, Day, Year) OCT 27 2000		32. Registrar's Signature [Signature]			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35696

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Michael Harley

2. Date of Death

Month Day Year
October 22, 2000

3. Time of Death

7:50PM

4a. Facility Name (If not institution, give street and number)

3411 Manis Road

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

219-54-8165

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 11, 1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3411 Manis Road

10f. Zip Code

20735

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

N/A

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Roofer

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

William C. Harley

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Proctor

19a. Informant's Name/Relationship (Type, Print)

Joseph R. Harley (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12550 Charles Street LaPlata, Maryland 20646

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Charles Cemetery

Date

October 26,
2000

20c. Location - City or Town, State

Indian Head, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee Funeral Home, Inc.

6633 Old Alexandria Ferry Road Clinton, MD20735

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. CARCINOMA OF THE OROPHARYNX

MOUTH

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D-18545

29d. Date signed (Month, Day, Year)

OCTOBER 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Phillip Wisotsky, M.D. 12070 Old Line Center, Waldorf Md 20602

31. Date filed (Month, Day, Year)

OCT 25 2000

32. Registrar's Signature

Benjamin A. Sparks

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35697

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Melvin Randolph Hunter				2. Date of Death Month Day Year October 17 2000		3. Time of Death 10:31 AM	
	4a. Facility Name (If not institution, give street and number) 6619 Sisalbed Drive				4b. City, Town, or Location of Death Capitol Heights		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 227-36-9382	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	8. Under 1 Year Months Days	9. Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 25, 1933		9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Capitol Heights		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 6619 Sisalbed Drive				10f. Zip Code 20743		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Afro-American		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Collega (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Operations Manager		16b. Kind of Business/Industry Retail		
17. Father's Name (First, Middle, Last) Granville Hunter				18. Mother's Name (First, Middle, Maiden Surname) Georgetta Jones				
19a. Informant's Name/Relationship (Type, Print) Anne Hunter (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6619 Sisalbed Drive Capitol Heights, MD 20743				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland State Veterans Cemetery		20c. Date Oct. 26, 2000		20d. Location - City or Town, State Cheltenham, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC COLORECTAL CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death ~ 1.5 yrs
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? N/A 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D18219		29d. Date signed (Month, Day, Year) 10/18/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 MERCANTILE LAKE CARGO MD 20774								
31. Date filed (Month, Day, Year) OCT 25 2000		32. Registrar's Signature 						

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35698

Hooks
Eathen
3/5-1

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Eathen J. Hooks, Sr.				2. Date of Death Month October Day 23 Year 2000		3. Time of Death 11 25 AM	
4a. Facility Name (If not institution, give street and number) Gladys Spellman Nursing Home				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince Georges	
5. Social Security Number 578-30-9039		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) 01/23/29	
9. Birthplace (State or Foreign Country) South Carolina		10a. State D.C.		10b. County Washington		10c. City, Town or Location Washington	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 629 21st Street, N.E.		10f. Zip Code 20002		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Barber		16b. Kind of Business/Industry Self-Employed			
17. Father's Name (First, Middle, Last) Elijah Hooks				18. Mother's Name (First, Middle, Maiden Surname) Mary Murphy			
19a. Informant's Name/Relationship (Type, Print) Olia M. Hooks				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 629 21st Street, N.E. Washington, D.C. 20002			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Location - City or Town, State 10/28/00 Brentwood, MD			
21. Signature of Funeral Service Licensee Wanda C. Bacon				22. Name and Address of Facility Bacon Funeral Home, Inc. 3347 14th Street, N.W. Washington, D.C. 20010			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease years Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral Infarction Diabetes Mellitus				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Paul A. DeVore		29c. License number D01852	
		29d. Date signed (Month, Day, Year) October 23 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. DeVore MD 4203 Queensbury Rd Hyattsville MD 20781							
31. Date filed (Month, Day, Year) OCT 26 2000				32. Registrar's Signature Benjamin P. Jones			

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35699

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES HOLMAN				2. Date of Death Month Day Year October 17, 2000		3. Time of Death 3:00 AM			
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges			
Funeral Director	5. Social Security Number 578-58-2779	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 13, 1943		9. Birthplace (State or Foreign Country) Washington DC		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince Georges	10c. City, Town or Location Clinton			10d. Inside City Limits Y Yes 2 No				
	10e. Street and Number 6001 Clinton Way				10f. Zip Code 20735		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Federal Police Officer			16b. Kind of Business/Industry General Services Admin				
	17. Father's Name (First, Middle, Last) Earl Holman				18. Mother's Name (First, Middle, Maiden Surname) Ozerbell Lockard					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Beverly S. Holman - Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6001 Clinton Way Clinton MD 20735						
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem		Date 10-24-00		20c. Location - City or Town, State Cheltenham, Maryland			
	21. Signature of Funeral Service Licensee Julia P. Marshall			22. Name and Address of Facility Marshall's Funeral Home, Inc, 4217 9th Street N.W. Washington DC 20011						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. RENAL FAILURE Due to (or as a consequence of): b. HEPATO-RENAL SYNDROME Due to (or as a consequence of): c. LIVER METASTASES Due to (or as a consequence of): d. CARCINOMA COLON Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANEMIA							23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature] MD		29c. License number 053885		29d. Date signed (Month, Day, Year) 10/17/2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VENKAT-S. RAMANAN 7501 SURRATTS ROAD #307 CLINTON MD 20735									
State Registrar	31. Date filed (Month, Day, Year) OCT 23 2000		32. Registrar's Signature [Signature]							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

00 35700

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Louise Howie				2. Date of Death Month OCTOBER Day 17 Year 2000		3. Time of Death 4:30PM	
	4a. Facility Name (If not institution, give street and number) Doctor's Community Hospital				4b. City, Town, or Location of Death Lanham		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 578 78 9925		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 5, 1918	9. Birthplace (State or Foreign Country) North Carolina
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Lanham			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 8200 Good Luck Road				10f. Zip Code 20706		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) Howard Foard				18. Mother's Name (First, Middle, Maiden Surname) Bessie Bruner				
19a. Informant's Name/Relationship (Type, Print) Mary Stinson / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1787 Village Green Drive Landover, Maryland 20785				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Location - City or Town, State 10-24-00 Brentwood, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, Maryland 20722				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <div style="border-left: 2px solid black; padding-left: 10px; margin-left: 100px;"> a. Myocardial infarction Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ </div>								Approximate Interval Between Onset and Death 30 minutes
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) 10/19/00
29b. Signature and title of certifier 				29c. License number 047603				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William DuBoys, MD 4000 Mitchellville Rd B216 Bowie, MD 20716								
31. Date filed (Month, Day, Year) OCT 23 2000				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

4

00 35701

ORIGINAL

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

00 35702

Reg. No.

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35703

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John J. Isenberg

2. Date of Death

Month Day Year
October 25, 2000

3. Time of Death

9:19PM

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

579-24-5274

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
4/28/23

9. Birthplace (State or Foreign Country)

Burham, PA.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5601 Kenwood St.

10f. Zip Code

20748

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

John J. Isenberg

18. Mother's Name (First, Middle, Maiden Surname)

Marie Rambler

19a. Informant's Name/Relationship (Type, Print)

Betty Jean Watson/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as item 10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland Veterans Cem. 11/2/2000

Date

11/2/2000

20c. Location - City or Town, State

Cheltenham, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home, P.A.
6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. CORONARY ATHEROSCLEROSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Two Hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Cardiac Failure

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

B 22910

29d. Date signed (Month, Day, Year)

OCTOBER 26th - 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASIFS GADRI, 4700 BERWYN HOUSE RD, COLLEGE PARK MD 20745

State
Registrar

31. Date filed (Month, Day, Year)

OCT 27 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35704

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JEROME ISAAH JOHNSON			2. Date of Death Month Day Year OCTOBER 21 2000		3. Time of Death 0715	
	4a. Facility Name (If not institution, give street and number) WILLIE JOHNSON LANE & HUFF RD.			4b. City, Town, or Location of Death PASADENA		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 216-27-1240	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 18 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 30, 1982	
	9. Birthplace (State or Foreign Country) WASH., DC						
Usual Residence of Decedent							
10a. State MD		10b. County HOWARD		10c. City, Town or Location COLUMBIA		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 9621 SEA SHADOW				10f. Zip Code 21046		10g. Citizen of What Country? U. S. A.	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGER		16b. Kind of Business/Industry MATTRESS WARE HOUSE	
17. Father's Name (First, Middle, Last) NATHAN TERRY JOHNSON				18. Mother's Name (First, Middle, Maiden Surname) WANDA C. NICHOLSON			
19a. Informant's Name/Relationship (Type, Print) FRANCES JOHNSON CRIM-GRANDMOTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9621 SEA SHADOW COLUMBIA, MD 21046			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FT. LINCOLN CEMETERY		Date 10/27/00		20c. Location - City or Town, State BRENTWOOD, MD	
21. Signature of Funeral Service Licensee <i>Theodore C. Pinckney</i>				22. Name and Address of Facility PINCKNEY-SPANGLER FUNERAL HOME 524 - 8TH ST., N. E. WASH., DC 20002			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death) a. <i>Gunshot wound of chest and abdomen</i> Due to (or as a consequence of):							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24e. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE					
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury 10-21-00		28b. Time of Injury 0400 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street		28d. Describe how injury occurred subject shot			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>					
		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) OCTOBER 21, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) OCT 24 2000		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Received of Mr. J. H. ...

for ...

[Signature]

Wm. A. ...

1887

1887

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35705

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jessie J. Jordan				2. Date of Death Month Day Year October 20 2000		3. Time of Death 8:43AM	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 237-52-1479	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 3, 1934		9. Birthplace (State or Foreign Country) North Carolina
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State District of Columbia		10b. County Washington		10c. City, Town or Location Washington		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 1017 - 50th St., N.E.				10f. Zip Code 20019		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dry Cleaner		16b. Kind of Business/Industry Self-Employed			
	17. Father's Name (First, Middle, Last) Orish Jordan				18. Mother's Name (First, Middle, Maiden Surname) Lula Chance			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Lillie Jordan - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1017 - 50th St., N.E. Wash., D.C. 20019			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garden Cem. Forest Hills Memorial		20c. Date 10/26/2000		20d. Location - City or Town, State Clinton, MD	
	21. Signature of Funeral Service Licensee John T. Stewart, III				22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. SEPTICEMIA, WITH SEPTIC SHOCK Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 21 CORONARY ARTERY DISEASE 22 CONGESTIVE HEART FAILURE, 23 CHRONIC RENAL FAILURE, 24 RESPIRATORY FAILURE, 25 DIFFUSE PULMONARY INFILTRATES 26 OBSTRUCTIVE JAUNDICE 27 PLEURAL EFFUSION 28 ASCITES 29 ANEMIA							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28b. Describe how injury occurred			
	28c. Location (Street and Number or Rural Route Number, City or Town, State)				28d. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	28e. Location (Street and Number or Rural Route Number, City or Town, State)				28f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Mohammed A. Mannan MD		29c. License number D24593	
	29d. Date signed (Month, Day, Year) 10.23.00				29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMMED A. MANNAN MD, 3331-TOLEDO TERRACE, HYATTSVILLE, MD. 20782			
	31. Date filed (Month, Day, Year) OCT 25 2000				32. Registrar's Signature Beverly B. Sparks			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35706

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Folly Romain Yves Koumebley				2. Date of Death Month Day Year October 10, 2000				3. Time of Death 3:03 A.M.		
	4a. Facility Name (If not institution, give street and number) Central Avenue and Addison Road				4b. City, Town, or Location of Death Seat Pleasant				4c. County of Death Prince George's		
Funeral Director	5. Social Security Number None		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 42 Yrs.		8. Date of Birth (Month, Day, Year) February 28, 1958		9. Birthplace (State or Foreign Country) Togo West Africa		
	Usual Residence of Decedent				10f. Zip Code 20879		10g. Citizen of What Country? Togo				
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Forestville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 6713 Gateway Boulevard				10f. Zip Code 20879				10g. Citizen of What Country? Togo			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: African American			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waiter				16b. Kind of Business/Industry Restaurant			
17. Father's Name (First, Middle, Last) Koum Lucien				18. Mother's Name (First, Middle, Maiden Surname) Christine N'Kounos							
19a. Informant's Name/Relationship (Type, Print) Kodjo Bruce/Uncle				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19775 Crystal Rock Drive, Germantown, Maryland 20874							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) City Cemetery		Date 10/30/00		20c. Location - City or Town, State Lom, Togo			
21. Signature of Funeral Service Licensee Shelton W. Hackett Sr.				22. Name and Address of Facility BIANCHI FUNERAL SERVICE 814 UPRR ST NW, DC 20004							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) 10-10-2000		28b. Time of Injury Found: 3:00 A		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject was a passenger in a taxi cab involved in a collision.	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street				28f. Location (Street and Number or Rural Route Number, City or Town, State) Central Avenue and Addison Rd., Seat Pleasant, MD							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Stephen Radentz, M.D.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) October 10, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201				31. Date filed (Month, Day, Year) OCT 27 2000				32. Registrar's Signature [Signature]			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35707

Amend #8. Per FH PGC 10-25-00 cr

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNIE RUTH JOHNSON KEARNEY						2. Date of Death Month Day Year October 21, 2000		3. Time of Death 5:00 pm	
	4a. Facility Name (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL						4b. City, Town, or Location of Death LANHAM		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 578-36-2465		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth Month Day Year 09-16-1927		9. Birthplace (State or Foreign Country) S.C.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County PRINCE GEORGES		10c. City, Town or Location NORTH BRENTWOOD				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 4509 CHURCH STREET				10f. Zip Code 20722		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry N/A		
	17. Father's Name (First, Middle, Last) EDGAR JOHNSON						18. Mother's Name (First, Middle, Maiden Surname) MAGGIE THOMAS			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) REV. JESSE J. KEARNEY-HUSBAND						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4509 CHURCH ST., N. BRENTWOOD, MD 20722			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MD VETERANS CEMETERY		20c. Location - City or Town, State 27-00 CHELTENHAM, MD			
	21. Signature of Funeral Service Licensee <i>B. E. Taylor</i>						22. Name and Address of Facility TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH. DC 20001			
	23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Coronary Artery Thrombosis Due to (or as a consequence of): c. Arterio Sclerotic Cardiovascular Disease Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 3 hrs 3 hrs Unknown									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION OBESITY									
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>James A. Horn, MD</i> ATTENDING						29c. License number 016197		29d. Date signed (Month, Day, Year) 10-23-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDROS A. LUNA, MD - 9326 LANTANA SWEEP RD., LANHAM, MD 20706										
State Registrar	31. Date filed (Month, Day, Year) OCT 25 2000				32. Registrar's Signature <i>[Signature]</i>					

ORIGINAL

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35708

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HERBERT MELVILLE KELSER				2. Date of Death Month OCTOBER Day 29 Year 2000		3. Time of Death 7:30 A.M.	
	4a. Facility Name (If not institution, give street and number) GENESIS ELDERCARE SPA CREEK				4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 579-30-5312		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) JULY 23, 1928	
	9. Birthplace (State or Foreign Country) WASHINGTON, D.C.		10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location ANNAPOLIS	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 35 MILKSHAKE LANE		10f. Zip Code 21403		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No NAVY If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALESMAN		16b. Kind of Business/Industry TIRE COMPANY			
	17. Father's Name (First, Middle, Last) HERBERT KELSER				18. Mother's Name (First, Middle, Maiden Surname) AGNES KELSER			
	19a. Informant's Name/Relationship (Type, Print) BARBARA FLEISHER-DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5512 ILCHESTER STREET CHURCHTON, MD. 20733			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY		20c. Location - City or Town, State 10-30-00 ALEXANDRIA, VA.			
	21. Signature of Funeral Service Licensee MO0479 <i>Michael O. Leonard</i>		22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary edema Due to (or as a consequence of): b. myocardial infarction Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 hr 1 hr							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia alcoholism						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier MO		29c. License number D0029571		29d. Date signed (Month, Day, Year) 10/29/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL Berez Crofton Rd. Crofton, md. 21114								
31. Date filed (Month, Day, Year) OCT 30 2000		32. Registrar's Signature <i>B. Jones</i>						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35709

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Katrina J. Lyons				2. Date of Death Month Day Year October 21, 2000				3. Time of Death 1:30 AM	
	4a. Facility Name (If not institution, give street and number) 15404 Deep Bottom Rd.				4b. City, Town, or Location of Death Darnestown				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579-24-6809		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 20, 1923		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent				10a. State MD		10b. County Montgomery		10c. City, Town or Location Darnestown	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 15404 Deep Bottom Rd		10f. Zip Code 20874		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3yrs		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Patent Officer				16b. Kind of Business/Industry US Government			
	17. Father's Name (First, Middle, Last) Emmett Johnson				18. Mother's Name (First, Middle, Maiden Surname) Gay Moody					
	19a. Informant's Name/Relationship (Type, Print) Geraldine V. Lee/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15404 Deep Bottom Rd. Darnestown, Md. 20874					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven		Date 10-27-00		20c. Location - City or Town, State Silver Spring, Md.			
	21. Signature of Funeral Service Licensee Julia P. Marshall				22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 20011					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Cerebrovascular Accident Due to (or as a consequence of): b. Ventricular Tachycardia Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Type II Diabetes Mellitus; Anti Phospholipid Syndrome				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 10/24/00		28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier [Signature]		29c. License number D0034445		29d. Date signed (Month, Day, Year) 10/24/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francisco C. King, M.D. 106 Irving St. N.W. Washington, DC. 20010				31. Date filed (Month, Day, Year) OCT 26 2000		32. Registrar's Signature [Signature]				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35710

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Lee Louia

2. Date of Death

Month Day Year
October 25, 2000

3. Time of Death

7:40 PM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

217-76-9849

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

41 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 4, 1959

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince Georges

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2510 Panther Lane

10f. Zip Code

20716

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Correctional Officer

16b. Kind of Business/Industry

County Corrections

17. Father's Name (First, Middle, Last)

James Robert Louia

18. Mother's Name (First, Middle, Maiden Surname)

Thelma Ann McIntyre

19a. Informant's Name/Relationship (Type, Print)

Shirley A. Louia wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2510 Panther Lane, Bowie, Md. 20716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakemont Mem. Gardens

Date

10-30-00

20c. Location - City or Town, State

Davidsonville, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Beall Funeral Home

6512 N.W. Crain Hwy., Bowie, Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure

Due to (or as a consequence of):

b. Cardiomyopathy

Due to (or as a consequence of):

c. Congestive heart failure

Due to (or as a consequence of):

d. Morbid obesity

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism

Anasarca

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

034722

29d. Date signed (Month, Day, Year)

10-26-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vicken K. Poochikian MD, 5632 Annapolis Rd., Suite 3, Bladensburg, Md.

31. Date filed (Month, Day, Year)

OCT 27 2000

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35711

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) Bertha A. Long				2. Date of Death Month Day Year October 21, 2000				3. Time of Death 11:40 PM	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Center				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 259-38-0499		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) July 9, 1915		9. Birthplace (State or Foreign Country) Tn	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Prince George's		10c. City, Town or Location Suitland				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 3416 Navy Day Drive				10f. Zip Code 20746		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) Domestic		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry Housekeeper					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Oscar A. Prince				18. Mother's Name (First, Middle, Maiden Surname) Nora Morgan					
	19a. Informant's Name/Relationship (Type, Print) Violet M. Walker				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3416 Navy Day Drive Suitland, MD 20746					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park		20c. Location - City or Town, State 10/25/00 Rockville, MD					
	21. Signature of Funeral Service Licensee <i>George P. Kalas</i>				22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Road, Oxon Hill, MD					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) a. Colon Carcinoma metastatic								Approximate Interval Between Onset and Death 2 months	
	Due to (or as a consequence of): b. Arteriosclerotic cardiovascular disease								> 5 years	
	Due to (or as a consequence of): c. Congestive heart failure								> 5 years	
	Due to (or as a consequence of): d. Leucopenia								< 1 week	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Hypertension								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and title of certifier Alain G. Champaloux MD				29c. License number D42049		29d. Date signed (Month, Day, Year) October, 22, 2000			
	30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Alain G. CHAMPALOUX MD. Upper Marlboro MD 20772									
State Registrar	31. Date filed (Month, Day, Year) OCT 23 2000				32. Registrar's Signature <i>Shirley B. Sparks</i>					
	ORIGINAL									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

LONG, BERTHA 10/21/00 2340

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35712

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNIE LIANG				2. Date of Death Month October Day 17 Year 2000				3. Time of Death 1942	
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE				4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 099-58-8902		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Jan. 18, 1914		9. Birthplace (State or Foreign Country) China		10a. State Md.		10b. County Montgomery		10c. City, Town or Location Rockville	
Usual Residence of Decedent										
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
10e. Street and Number 9701- Veirs Dr.,										
10f. Zip Code 20850										
10g. Citizen of What Country? USA										
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced										
12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:										
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:										
14. Race - American Indian, Black, White, etc. Specify: Chinese										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Collega (1-4 or 5+)										
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker										
16b. Kind of Business/Industry At Home										
17. Father's Name (First, Middle, Last) Wen Biao Kwan										
18. Mother's Name (First, Middle, Maiden Surname) Shio Ching Lu										
19a. Informant's Name/Relationship (Type, Print) Loretta Tang-Daughter										
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13880- Grey Colt Dr., Gaithersburg, Md. 20878										
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)										
20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory-10/20-Alexandria, Va.										
20c. Location - City or Town, State										
21. Signature of Funeral Service Licensee W. H. Hysong										
22. Name and Address of Facility HYSONG CO., INC. 6510-16th ST., NW, WASH., DC										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Closed Head Injury Due to (or as a consequence of): Accident on Road Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acoustic Neuroma										
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day, Year) October 17, 2000										
28b. Time of Injury UNKNOWN M										
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
28d. Describe how injury occurred WITNESSED FALL										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) NATIONAL LUTHERAN HOME										
28f. Location (Street and Number or Rural Route Number, City or Town, State) 9701 VEIRS DRIVE, ROCKVILLE, MD										
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier (Signature)										
29c. License number 015236										
29d. Date signed (Month, Day, Year) October 18, 2000										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL E. MANGUS, MD. 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852										
31. Date filed (Month, Day, Year) OCT 23 2000										
32. Registrar's Signature (Signature)										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

6-20-11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35713

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PHYLLIS JANE MCGILL				2. Date of Death Month Day Year October 20, 2000		3. Time of Death 1240 pm	
	4a. Facility Name (If not institution, give street and number) Intersection of Route 214 and Campus Way				4b. City, Town, or Location of Death Largo		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 233-58-4048		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) May 19, 1936	
	9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Upper Marlboro	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 6 Herrington Drive		10f. Zip Code 20774		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher's Assistant		16b. Kind of Business/Industry Government				
17. Father's Name (First, Middle, Last) Harold Waller, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Nannie Brown				
19a. Informant's Name/Relationship (Type, Print) Pamela McGill/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Herrington Drive, Upper Marlboro, Maryland 20774				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		Date 10/28 2000		20c. Location - City or Town, State Landover, Maryland		
21. Signature of Funeral Service Licensee Nancy A. Perentis				22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MULTIPLE INJURIES Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 10/20/00		28b. Time of Injury 1240 PM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred DRIVER OF CAR INVOLVED IN MOTOR VEHICLE COLLISION		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ROADWAY		28f. Location (Street and Number or Rural Route Number, City or Town, State) INTERSECTION RT 214 AND CAMPUS WAY, LARGO, MD.				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier [Signature]				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) October 21, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) OCT 25 2000				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35714

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy M. Morris		2. Date of Death Month Day Year October 19, 2000		3. Time of Death 11:30 P
	4a. Facility Name (If not institution, give street and number) Mariner Health Center		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery
Funeral Director	5. Social Security Number 268 18 5670	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	8. Date of Birth (Month, Day, Year) Nov 23, 1916	9. Birthplace (State or Foreign Country) North Dakota
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Silver Spring		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 901 Arcola Avenue		10f. Zip Code 20902		10g. Citizen of What Country? United States
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Personnel Office Worker
	17. Father's Name (First, Middle, Last) Elmer Ray McGuire		18. Mother's Name (First, Middle, Maiden Surname) Clara Landen		19a. Informant's Name/Relationship (Type, Print) Thomas F. Morris (SON)
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6705 Pawtucket Road, Bethesda, Maryland 20817		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory October 21, 2000
	20c. Location - City or Town, State Clinton, Maryland		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Cardiovascular Accident Due to (or as a consequence of): c. Parkinson's Disease Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 1995 1995 1995		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D17729		29d. Date signed (Month, Day, Year) October 19, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George B. Patrick, III, MD 9221 Colesville Road, Silver Spring, MD 20910					
31. Date filed (Month, Day, Year) OCT 25 2000		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35715

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Willie Mayo, Sr.				2. Date of Death Month Day Year October 21 2000				3. Time of Death 3:41PM	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 227-26-3522		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Dec. 16, 1930		9. Birthplace (State or Foreign Country) Virginia		10a. State District of Columbia		10b. County Washington		10c. City, Town or Location Washington	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 5929 East Capitol St., S.E. #214		10f. Zip Code 20019		10g. Citizen of What Country? United States				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: African American				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Private						
17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Unknown						
19a. Informant's Name/Relationship (Type, Print) Donald Mayo, Sr. - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Randolph Pl., N.W. Wash., D.C. 20001						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem.		Date 10/30/2000		20c. Location - City or Town, State Arlington, VA				
21. Signature of Funeral Service Licensee John T. Stewart, III		22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019								
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sepsis Sacroal ulcer Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End stage renal disease, Hypertension Cerebrovascular accident, Peripheral Vascular disease				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature] MD		29c. License number D51083		29d. Date signed (Month, Day, Year) 10/22/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yusa. O. Yusuf MD 6712 VILLAGE PARK DR. GREENBELT MD 20770		31. Date filed (Month, Day, Year) OCT 24 2000		32. Registrar's Signature [Signature]						

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 35716

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Patrick Michael Madison				2. Date of Death Month Day Year October 22, 2000		3. Time of Death 3:15 pm		
	4a. Facility Name (If not institution, give street and number) Doctor's Community Hospital				4b. City, Town, or Location of Death Lanham		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 212-66-4530	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 44 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 31, 1956		9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location College Park			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 9808 47th Place			10f. Zip Code 20740		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Police Officer		16b. Kind of Business/Industry Prince George's County				
	17. Father's Name (First, Middle, Last) Charles Madison				18. Mother's Name (First, Middle, Maiden Surname) Margaret Fleming				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Donna J. Blades - Friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4429 244th Street, SE, Woodinville, WA 98072				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		20c. Location - City or Town, State Clinton, Maryland		20d. Date 10/27/00		
	21. Signature of Funeral Service Licensee		22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): b. METASTATIC CARCINOMA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 30 min								
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE								
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
State Registrar	29b. Signature and title of certifier Martin O. Weltz, MD				29c. License number D23743		29d. Date signed (Month, Day, Year) 10-23-00		
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARTIN WELTZ, MD 7525 GREENWAY CTR DR, GREENBELT, MD 20776								
	31. Date filed (Month, Day, Year) OCT 24 2000				32. Registrar's Signature B. Sparks				

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35717

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rita H. McKenna

2. Date of Death

Month Day Year
October 22, 2000

3. Time of Death

6:43 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

083-07-7856

6. Sex

1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 28, 1916

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3435 S. Leisure World Blvd. #2-B

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Edward Walsh

18. Mother's Name (First, Middle, Maiden Surname)

Harriet Lawlor

19a. Informant's Name/Relationship (Type, Print)

Kathleen M. Stewart

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

24 Seaside Court Manchester MD 63011

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven

Date

10-26-2000

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home

6160 Oxon Hill Road, Oxon Hill, Maryland 20745

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Cecal Volvulus

Due to (or as a consequence of):

2 weeks

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Breast Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

00055243

29d. Date signed (Month, Day, Year)

October 22, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John Morrissey MD 18111 Prince Phillip Drive Olney, MD 20832

31. Date filed (Month, Day, Year)

OCT 25 2000

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

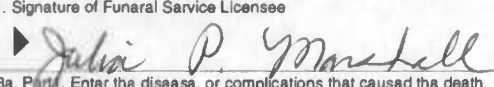
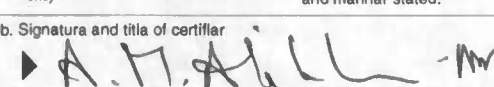

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35718

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BERNARD MORRIS NEDAB					2. Date of Death Month October Day 20 Year 2000		3. Time of Death 5:27 AM	
	4a. Facility Name (If not institution, give street and number) Fort Washington Hospital					4b. City, Town, or Location of Death Fort Washington		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 069-12-6427		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 13, 1919		9. Birthplace (State or Foreign Country) Melfa, Virginia
	Usual Residence of Decedent								
10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Camp Springs			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 5615 Lansing Drive					10f. Zip Code 20748		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security Officer			16b. Kind of Business/Industry Department of Navy	
17. Father's Name (First, Middle, Last) Chester Nedab					18. Mother's Name (First, Middle, Maiden Surname) Lucy Unknown				
19a. Informant's Name/Relationship (Type, Print) Letitia Fields Nedab - Wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5615 Lansing Drive, Camp Springs MD 20748				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 10-24-00 Alexandria, VA		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington DC 20011				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> Immediata Causa (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Septic shock Due to (or as a consequence of): c. Acute Renal Failure Due to (or as a consequence of): d. </div> <div style="width: 35%; text-align: center;"> Days Days Days </div> </div>									
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 					29c. License number D46046		29d. Date signed (Month, Day, Year) 10-20-2000		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) AMIR ALIKHANI 118 LaGrange Ave, P.O. Box 1890, La Plata, MD									
31. Date filed (Month, Day, Year) OCT 23 2000			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35719

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Grimshaw Johnson Olive				2. Date of Death Month 10 Day 24 Year 2000		3. Time of Death 2:30p.m.			
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 547-36-7656		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) 05/02/20			
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State DC		10b. County Washington		10c. City, Town or Location Washington			
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1330 7th Street, N.W. #601		10f. Zip Code 20001		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security Guard		16b. Kind of Business/Industry Rental Property					
	17. Father's Name (First, Middle, Last) Unk.		18. Mother's Name (First, Middle, Maiden Surname) Myrtle Unk.							
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Anna Clark Olive				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1330 Massachusetts Avenue, N.W.; Washington, DC 20005					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Hills Cemetery		Date 11-4-00		20c. Location - City or Town, State Clinton, Maryland			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Wanda C. Bacon CCD361				22. Name and Address of Facility Bacon Funeral Home, Inc. 3447 14th Street, N.W. Washington, D.C. 20010					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerotic Cardiovascular Disease							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier Myron L. Lenkin				29c. License number DD6674		29d. Date signed (Month, Day, Year) 10/26/2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYRON L. LENKIN MD 2309 SHOREFIELD RD WHEATON MD 20902									
	31. Date filed (Month, Day, Year) OCT 26 2000				32. Registrar's Signature [Signature]					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35720

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANTONIO BONTUGAN PEREZ				2. Date of Death Month Day Year OCT 24 2000		3. Time of Death 9:00 AM			
	4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY			
Funeral Director	5. Social Security Number 554-32-9789		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 6, 1919		9. Birthplace (State or Foreign Country) Agana, Guam	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Forest Heights				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 5712 Ottawa St.				10f. Zip Code 20745		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Retired If Yes, Give Year or Dates: 1971		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Guamanian/Chamorro			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) US Navy				16b. Kind of Business/Industry Military			
	17. Father's Name (First, Middle, Last) Joaquin Cruz Perez				18. Mother's Name (First, Middle, Maiden Surname) Ana Cruz Bontugan					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Margarita S. Perez/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as item 10					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington Nat. Cemetery		Date 11/2/2000		20c. Location - City or Town, State Arlington, VA.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745					
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier  MD				29c. License number D-0053919			29d. Date signed (Month, Day, Year) 26 OCT 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R.V. BARTHEL, LT, MC, USN						NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600				
31. Date filed (Month, Day, Year) OCT 27 2000		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35721

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANGELA PATTERSON		2. Date of Death Month Day Year OCTOBER 18, 2000		3. Time of Death 07:11 AM
	4a. Facility Name (If not institution, give street and number) 2700 BARKE STREET		4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY
Funeral Director	5. Social Security Number 579-96-7835	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 31 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) June 3, 1969		9. Birthplace (State or Foreign Country) Wash. D.C.		
Usual Residence of Decedent					
10a. State D.C.		10b. County Washington		10c. City, Town or Location Washington	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 313 Varnum Street, N.W.		10f. Zip Code 20011	
10g. Citizen of What Country? U.S.A.		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5yrs	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Radiologist		16b. Kind of Business/Industry Private		17. Father's Name (First, Middle, Last) Futman Patterson	
18. Mother's Name (First, Middle, Maiden Surname) Henriolla Stoddard		19a. Informant's Name/Relationship (Type, Print) Henriolla Stoddard/Mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 Varnum St., N.W. Wash. D.C. 20011	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft Lincoln Cemetery 11/1/00		20c. Location - City or Town, State Brentwood Md.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Johnson & Jenkins Inc. 716 Kennedy St., N.W. Wash D.C. 20011			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) a. BRONCHOPNEUMONIA Due to (or as a consequence of): b. LONG-TERM COMPLICATION OF ENCEPHALITIS Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number OCME		29d. Date signed (Month, Day, Year) OCTOBER 30, 2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) NOV 01 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35722

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Maurice PETERS

2. Date of Death

Month Day Year
10-17-2000

3. Time of Death

6:30 PM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Mariner Health of Bethesda

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

086-16-3294

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
06-06-13

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5721, Grosvenor Lane

10f. Zip Code

20814

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrical Engineer

16b. Kind of Business/Industry

Electrical

17. Father's Name (First, Middle, Last)

Leonard Peters

18. Mother's Name (First, Middle, Maiden Surname)

Ella Balch

19a. Informant's Name/Relationship (Type, Print)

Annabel G. Poms/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6808 Millwood Rd, Bethesda, MD 20817

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

National Crematory

Data

102300

20c. Location - City or Town, State

Falls Church, VA

21. Signature of Funeral Service Licensee

W. A. H. Murray

22. Name and Address of Facility

Joseph Gawler's Sons
5130 Wisc. Ave, NW, Washington, DC 20016

23e. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

P. Talwar

29c. License number

D 36552

29d. Date signed (Month, Day, Year)

OCTOBER 17 '2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. Talwar, 50 W. Edmonston Dr. #401 Rockville MD 20852

31. Date filed (Month, Day, Year)

OCT 23 2000

32. Registrar's Signature

B. A. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35723

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Shirl Ann Parker		2. Date of Death Month Day Year OCT. 19, 2000		3. Time of Death 1655 PM	
	4a. Facility Name (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL		4b. City, Town, or Location of Death LANHAM		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 578-70-6659	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 6/28/51
	9. Birthplace (State or Foreign Country) Wash., D.C.					
Usual Residence of Decedent						
10a. State D.C.		10b. County N/A		10c. City, Town or Location Washington		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number 318 34th Street, N.E.			10f. Zip Code 20019		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 yr.			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Md State Gov't.	
17. Father's Name (First, Middle, Last) James E. Parker			18. Mother's Name (First, Middle, Maiden Surname) Rosie Turner			
19a. Informant's Name/Relationship (Type, Print) Rosie Parker/Mother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 318 34th St., N.E., Wash., D.C. 20019			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Moses Cemetery		20c. Location - City or Town, State Lothian, Md.		
21. Signature of Funeral Service Licensee <i>Dany A. Pratt</i>		22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. 20019				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Pulmonary Thromboemboli</i> Due to (or as a consequence of): <i>Deep Vein Thromboses</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Cellulitis; Obesity; Asthma; Diabetes mellitus; Dilated Cardiomyopathy</i>						Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cellulitis; Obesity; Asthma; Diabetes mellitus; Dilated Cardiomyopathy</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certify (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier <i>J. Larson</i>		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) OCT. 20, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>J. Larson</i> 111 Penn Street, Baltimore, Maryland 21201						
31. Date filed (Month, Day, Year) OCT 24 2000		32. Registrar's Signature <i>B. Sparks</i>				

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35724

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

DOROTHY QUEEN

2. Date of Death

Month Day Year
OCT 23 2000

3. Time of Death

23:43

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

579-40-6531

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 15, 1919

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

Prince George's

10c. City, Town or Location

Capitol Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

624 Cabin Branch Drive

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
7th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Charles Nichols

18. Mother's Name (First, Middle, Maiden Surname)

Mary Blake

19a. Informant's Name/Relationship (Type, Print)

Reginald Queen Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

824 Balboa Ave. Capitol Heights, MD. 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

10/28/00

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

Debra J. Jenkins

22. Name and Address of Facility

J.B. Jenkins Funeral Home

7474 Landover Rd. Landover, MD. 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery

Due to (or as a consequence of):

b. Aortic insufficiency

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d. Respiratory failure

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

Dr. M.D.

29c. License number

46260

29d. Date signed (Month, Day, Year)

OCT. 25 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. SAEED KOO LAEE, 5632 ANNAPOLIS ROAD, SUITE #4 BUDENSBURG MD

State
Registrar

31. Date filed (Month, Day, Year)

OCT 27 2000

32. Registrar's Signature

Debra J. Jenkins

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35725

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Quintero				2. Date of Death Month Day Year October 14, 2000		3. Time of Death 9:29 AM		
	4a. Facility Name (If not institution, give street and number) Future Care Pineview				4b. City, Town, or Location of Death CLinton		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 228-30-8827	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 20, 1923		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's		10c. City, Town or Location Ft. Washington			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 2308 Brinkley Road			10f. Zip Code 20744		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry Government			
	17. Father's Name (First, Middle, Last) Melvin Adams				18. Mother's Name (First, Middle, Maiden Surname) Mary Alice Harrison				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Willie B. Davis Jr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2308 Brinkley Road, Ft. Washington MD 20744				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Location - City or Town, State Landover, MD		20d. Date 10/20/00		
	21. Signature of Funeral Service Licensee <i>Prince Edwards</i>				22. Name and Address of Facility Hodges and Edwards Funeral Home 3910 Silver Hill Road, Suitland, MD 20746				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pneumonia Due to (or as a consequence of): b. Urosepsis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death Minutes Weeks	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Alzheimer's disease Parkinson's syndrome							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Michael Pimentel MD</i>				29c. License number MD H0042445		29d. Date signed (Month, Day, Year) October 23, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 Post Office Road, 1-A, Waldorf, MD 20602 Michael Pimentel MD.									
State Registrar	31. Date filed (Month, Day, Year) OCT 24 2000		32. Registrar's Signature <i>[Signature]</i>						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35726

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Verma E. Roy

2. Date of Death

Month Day Year
Oct. 22, 2000

3. Time of Death

11:30 p.m.

4a. Facility Name (If not institution, give street and number)

Fairland Adventist Nursing Home

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

223-40-1104

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 20, 1914

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Silver Springs

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8546 11th Ave.

10f. Zip Code

20903

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Irvin C. Carter

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Evans Baltimore

19a. Informant's Name/Relationship (Type, Print)

Raymond Roy /Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8546 11th Ave., Silver Springs, Md. 20903

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bethel Cemetery

Date

10-27-00 Alex., Va.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Phillip Bell

22. Name and Address of Facility

Lewis Funeral Home
311 N. Patrick St., Alex., Va. 22314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Multiple myeloma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate interval between Onset and Death

1 yr.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Myron L. Lenkin

29c. License number

006674

29d. Date signed (Month, Day, Year)

10/27/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MYRON L. LENKIN M.D.

2309 SHOREFIELD RD
WHEATON MD 20902

31. Date filed (Month, Day, Year)

OCT 27 2000

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 35727

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary M. Ross				2. Date of Death Month Day Year October 20, 2000		3. Time of Death 8:43 AM	
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 579-60-8076		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) November 1, 1915	
	9. Birthplace (State or Foreign Country) Washington, D.C.		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Capital Heights	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 6513 Joplin Street		10f. Zip Code 20743		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dietician		16b. Kind of Business/Industry D.C. General Hospital			
	17. Father's Name (First, Middle, Last) Arthur Brooks				18. Mother's Name (First, Middle, Maiden Surname) Landonia Brooks			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. William Ross (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6513 Joplin Street Capital Heights, Maryland 20743			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) National Harmony Memorial Park		20c. Location - City or Town, State Landover, Maryland		20d. Date 10/27/2000	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Janet C. Henderson</i>				22. Name and Address of Facility ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cardio Respiratory Arrest</i> Due to (or as a consequence of): b. <i>Arrhythmias</i> Due to (or as a consequence of): c. <i>CHF</i> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Renal Failure</i> <i>Hypertension</i> <i>Insulin Dependent Diabetes</i>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>Boon J. J. Jr. MD</i>				29c. License number D005625		29d. Date signed (Month, Day, Year) 10/24/2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Russ Foster Jr. MD Kaiser Permanente, Largo Md Ctr, 1221 Mercantile Ctr Largo, MD 20774</i>							
State Registrar	31. Date filed (Month, Day, Year) OCT 25 2000				32. Registrar's Signature <i>James A. Sparks</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35728

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BARBARA ANN ROWE				2. Date of Death Month October Day 20 , Year 2000		3. Time of Death 7:40PM	
	4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL				4b. City, Town, or Location of Death TAKOMA PARK		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 577-50-5707	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 8-22-35		9. Birthplace (State or Foreign Country) Greenville, SC
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State D.C.	10b. County N/A	10c. City, Town or Location Washington			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 4100- 13th Place, N.E.				10f. Zip Code 20017		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher Aide			16b. Kind of Business/Industry N/A		
	17. Father's Name (First, Middle, Last) Collier Cox				18. Mother's Name (First, Middle, Maiden Surname) Rosalee Kilgore			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Jeanette Rowe/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5400- Bass Place, S.E. Washington, DC 20019			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Quantico National Cem.		Date 10/30/00		20c. Location - City or Town, State Triangle, Va.	
	21. Signature of Funeral Service Licensee <i>Shelton W. Hackett A.</i>				22. Name and Address of Facility Hackett's Funeral Chapel, Inc. 814- Upshur Street, N.W.			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Cardiogenic Shock</i> Due to (or as a consequence of): b. <i>Myocardial Infarction</i> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number 17047635		29d. Date signed (Month, Day, Year) Oct-23, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurence R. Kelley, MD. 7600 Camell Ave. Takoma Park, MD.								
31. Date filed (Month, Day, Year) OCT 25 2000		32. Registrar's Signature <i>[Signature]</i>						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35729

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Douglas Alan Robinson

2. Date of Death

Month Day Year
October 16, 2000

3. Time of Death

4:13PM

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

280-42-2305

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

53

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
March 24, 1914

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Brandywine

10d. Inside City Limits

1□ Yes 2□ No

10e. Street and Number

9100 Bank Street

10f. Zip Code

20613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1□ Never Married 2X Married
3□ Widowed 4□ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1X Yes 2□ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2X No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Househusband

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Clarence Robinson

18. Mother's Name (First, Middle, Maiden Surname)

Cecilia Wellinghoff

19a. Informant's Name/Relationship (Type, Print)

Carolyn Robinson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9100 Bank Street Brandywine, Maryland 20613

20a. Method of Disposition

1□ Burial 2X Cremation 3□ Removal from State
4□ Donation 5□ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lee Crematory

October 20,

2000

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

▶ *Sh. G. Smith*

22. Name and Address of Facility

Lee Funeral Home, Inc.

6633 Old Alexandria Ferry Road Clinton, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)a. *Acute Myocardial Infarction*

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death
20735

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3X Probably 4□ Unknown

24a. Was an autopsy
performed?

1□ Yes 2X No

24b. Were autopsy findings
available prior to
completion of cause
of death?N/A
1□ Yes 2□ No25. Was case referred to medical
examiner?

1□ Yes 2X No

Hospital:

1□ Inpatient

2□ ER/Outpatient

3X DOA

Other:

26. Place of Death (Check only one)

4□ Nursing Home 5□ Residence 6□ Other (Specify)

27. Manner of Death

1X Natural 5□ Pending
2□ Accident investigation
3□ Suicide 6□ Could not be
4□ Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

▶ *Nalin Mathur*

29c. License number

D52289

29d. Date signed (Month, Day, Year)

10/18/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nalin Mathur 11345 Pembroke Sq. #104, Waldorf, Md

31. Date filed (Month, Day, Year)

OCT 25 2000

32. Registrar's Signature

▶ *B. Sparks*State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Dr. N. Mathur 10/18/2000 Robinson, Douglas

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35730

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Russell Reid

2. Date of Death
Month Day Year
October 19, 20003. Time of Death
16:45pmFuneral
Director

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

239-78-1697

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Sept. 21, 1946

9. Birthplace (State or Foreign Country)

Goldsboro, N.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Mitchellville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10209 Tulip Tree Dr.

10f. Zip Code

20721

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bus Operator

16b. Kind of Business/Industry

Metro

17. Father's Name (First, Middle, Last)

Willie Allen Reid

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Johnson

19a. Informant's Name/Relationship (Type, Print)

Peggy Reid/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10209 Tulip Tree Dr. Mitchellville, Md. 20721

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wayne Memorial Park

Date

10/28/00

20c. Location - City or Town, State

Goldsboro, NC

21. Signature of Funeral Service Licensee

Keith G. Gorge M.O.D.O.S.

22. Name and Address of Facility

Alexander S. Pope Funeral Homes

5538 Marlboro Pike/Forestville, Md.

20747

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Hepatocellular Carcinoma
Due to (or as a consequence of):c. Cirrhosis
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James Catavene

29c. License number

D30318

29d. Date signed (Month, Day, Year)

10/19/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Catavene 3001 Hospital Dr, Cheverly Md.

31. Date filed (Month, Day, Year)

OCT 23 2000

32. Registrar's Signature

James S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35731

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CURTIS R. SUTTON SR.				2. Date of Death Month 10 Day 25 Year 2000		3. Time of Death 7:35AM.		
	4a. Facility Name (If not institution, give street and number) ST. THOMAS MORE NURSING HOME HYATTSVILLE				4b. City, Town, or Location of Death PRINCE GEORGES		4c. County of Death PRINCE GEORGES		
Funeral Director	5. Social Security Number 578645498		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth (Month, Day, Year) 1-18-48		
	9. Birthplace (State or Foreign Country) WASH., D.C.		10a. State MD.		10b. County PRINCE GEORGES		10c. City, Town or Location LAUREL		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 9568 Muir Kirk Road		10f. Zip Code 20708		10g. Citizen of What Country? UNITED STATES	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COUNSELOR		16b. Kind of Business/Industry ARE GROUP HOME		17. Father's Name (First, Middle, Last) MAURICE SUTTON		18. Mother's Name (First, Middle, Maiden Surname) CORA JONES	
19a. Informant's Name/Relationship (Type, Print) PATRICE JONES		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3567 LAURELVIEW CT., LAUREL, MD. 20724		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GEORGE WASHINGTON		20c. Location - City or Town, State ADDELPHI	
21. Signature of Funeral Service Licensee Glenn A. Henry, MD 1178		22. Name and Address of Facility B.K. HENRY FUNERAL HOME WASH. DC. 20002		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Carcinoma of the Lung Due to (or as a consequence of): Metastasis to Liver and Lymph Nodes Due to (or as a consequence of): Pneumonia, Bilateral Lower Lobes Due to (or as a consequence of): HIV (+)		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnutrition Dehydration		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Esmerando O. Juanitez, MD		29c. License number D0051122		29d. Date signed (Month, Day, Year) 10/27/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Esmerando O. Juanitez, MD. 2802 Rhode Island Ave. NE. Wash. DC. 20018	
31. Date filed (Month, Day, Year) OCT 27 2000		32. Registrar's Signature [Signature]		33. State Registrar		34. State Registrar		35. State Registrar	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35732

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leocadia M. Sayson				2. Date of Death Month Day Year October 26, 2000		3. Time of Death 5:18AM	
	4a. Facility Name (If not institution, give street and number) Fort Washington Hospital				4b. City, Town, or Location of Death Ft. Washington		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 579-82-5843	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 3, 1914		9. Birthplace (State or Foreign Country) Philippine Is.
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Accokeek		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 15501 Emily Court				10f. Zip Code 20607		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Filipino		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry At Home		
17. Father's Name (First, Middle, Last) Domingo Magalong				18. Mother's Name (First, Middle, Maiden Surname) Maria Rosario				
19a. Informant's Name/Relationship (Type, Print) Rene Mendenilla/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as item 10				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery 11/4/2000		20c. Location - City or Town, State Clinton, Md.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. Acute Myocardial Infarction Due to (or as a consequence of):					1 Day	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of):					Years	
		c. Due to (or as a consequence of):						
		d. Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D-18545		29d. Date signed (Month, Day, Year) October 26, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip Wisotsky, M.D. 12070 Old Line Center Waldorf, Md. 20602								
31. Date filed (Month, Day, Year) OCT 27 2000		32. Registrar's Signature 						

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35733

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Erna J. Schaub

2. Date of Death

October 24, 2000 257am

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

AA COUNTY

5. Social Security Number

578 62 3238

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 5, 1910

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Maryland Anne Arundel

10b. County

Crofton

10c. City, Town or Location

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1687 Fremont Court

10f. Zip Code

21114

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Ludwig Muench

18. Mother's Name (First, Middle, Maiden Surname)

Paula Jost

19a. Informant's Name/Relationship (Type, Print)

Fred Schaub

Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1687 Fremont Court Crofton Maryland 21114

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Washington National Cemetery

Date

Oct. 30, 2000

20c. Location - City or Town, State

Suitland Maryland

21. Signature of Funeral Service Licensee

Michael S. Bigler

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Coronary Heart Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

Urinary Tract Infection

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Paul S. Rhodes, M.D.

29c. License number

D22028

29d. Date signed (Month, Day, Year)

10 24 00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Paul S. Rhodes, M.D. 1667 Crofton Centre #1 Crofton, MD 21114

State
Registrar

31. Date filed (Month, Day, Year)

OCT 27 2000

32. Registrar's Signature

B. J. J. J.

ORIGINAL

SCHAUB, ERNA J.
Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35734

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thelma Morris Strohmaier		2. Date of Death Month October Day 18 Year 2000		3. Time of Death 2038
	4a. Facility Name (If not institution, give street and number) Suburban Hospital		4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery
Funeral Director	5. Social Security Number 219-14-8239	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) August 30, 1923		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Upper Marlboro	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 9534 Croom Road			10f. Zip Code 20772		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 4			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Librarian		16b. Kind of Business/Industry Library Montgomery County
17. Father's Name (First, Middle, Last) Charles William Morris			18. Mother's Name (First, Middle, Maiden Surname) Gladys Mae Parsons		
19a. Informant's Name/Relationship (Type, Print) Edward Strohmaier (Husband)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9534 Croom Road Upper Marlboro, MD 20772		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory		20c. Location - City or Town, State Clinton, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. CARDIOGENIC SHOCK			Approximate Interval Between Onset and Death 2 DAYS
		Due to (or as a consequence of):			
		b. CRITICAL AORTIC STENOSIS			2 YEARS
		Due to (or as a consequence of):			
		c.			
		Due to (or as a consequence of):			
		d.			
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No N/A	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D-20535		29d. Date signed (Month, Day, Year) 10/19/2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROGER SWENSON, JR MD 6410 ROCKLEDGE DR #200 BETHESDA, MD					
31. Date filed (Month, Day, Year) OCT 25 2000		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

00 35735

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIE SCOTT			2. Date of Death Month Day Year OCTOBER 20, 2000		3. Time of Death 2:06am	
	4a. Facility Name (If not institution, give street and number) BRADFORD OAKS NURSING HOME			4b. City, Town, or Location of Death CLINTON		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 577-38-1078	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) FEB 28, 1918	9. Birthplace (State or Foreign Country) SUMMERTON, SC
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD	10b. County PRINCE GEORGES	10c. City, Town or Location CLINTON		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 10620 TRIFT RD			10f. Zip Code 20735		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEKEEPER		16b. Kind of Business/Industry PRIVATE		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) JOHN BROWN			18. Mother's Name (First, Middle, Maiden Surname) JULIA LAWSON			
	19a. Informant's Name/Relationship (Type, Print) SUSIE PEEPLES/ DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10620 THRIFT RD, CLINTON, MD 20735			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK		20c. Location - City or Town, State 10-25-00 LANDOVER, MD		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOME 5538 MARLBORO PIKE, FORESTVILLE, MD 20748				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death
	a. Respiratory Failure Due to (or as a consequence of):						
	b. Congestive Heart Failure Due to (or as a consequence of):						
	c. Bilateral Pleural Effusions Due to (or as a consequence of):						
d. COPD Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NIDDM, HTN, PVD						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.		29b. Signature and title of certifier 		29c. License number D0053219		29d. Date signed (Month, Day, Year) 10.23.2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TE POST OFFICE ROAD, WILDORF, MD 20602							
31. Date filed (Month, Day, Year) OCT 23 2000		Registrar's Signature 					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene


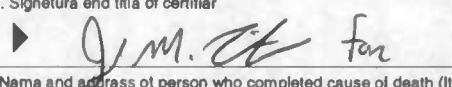

00 35736

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) METHYL LEE SUTTON				2. Date of Death Month Day Year OCT 18, 2000				3. Time of Death 8:15am	
	4a. Facility Name (If not institution, give street and number) 3730 DUNLAP ST				4b. City, Town, or Location of Death TEMPLE HILLS				4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 156-26-1758		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) APRIL 21, 1912		9. Birthplace (State or Foreign) HONOLULU HAWAII		10a. State MD		10b. County PRINCE GEORGES		10c. City, Town or Location TEMPLE HILLS	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 3730 DUNLAP ST				10f. Zip Code 20748		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry PRIVATE			
	17. Father's Name (First, Middle, Last) JOHN HUMBERT				18. Mother's Name (First, Middle, Maiden Surname) LOIS SAMPSON					
	19a. Informant's Name/Relationship (Type, Print) MARJORIE BETHEA / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3730 DUNLAP ST, TEMPLE HILLS, MD 20748					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FT. Lincoln Cemetery		Data 10/25/00		20c. Location - City or Town, State Brentwood, Md.			
	21. Signature of Funeral Service Licensed <i>Harry L. Simmons</i>		22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cardiac Disease</i> Due to (or as a consequence of): b. <i>Hypertension</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Breast Cancer Diverticulosis</i>									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Officer</i>				29c. License number D26352				29d. Date signed (Month, Day, Year) Oct 19 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Officer 9131 Pincatway Rd #540 Clinton</i>										
State Registrar	31. Date filed (Month, Day, Year) OCT 23 2000				32. Registrar's Signature <i>Shirley B. Spauls</i>					

ORIGINAL

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Johnny Bernard Slater				2. Date of Death Month Day Year SEPTEMBER 16 2000		3. Time of Death 1300	
	4e. Facility Name (If not institution, give street and number) 2700 BLK E. BALTIMORE ST.				4b. City, Town, or Location of Death BAITIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 251-39-4997		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 36 Yrs.		8. Date of Birth (Month, Day, Year) 9-12-64	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) South Carolina		10a. State Pa		10b. County Bucks	
10c. City, Town or Location Warminister				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 616 Sky Hawk		
10f. Zip Code 18974				10g. Citizen of What Country? USA		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Totally Disabled		16b. Kind of Business/Industry N-A		
17. Father's Name (First, Middle, Last) John Slater				18. Mother's Name (First, Middle, Maiden Surname) Nellie Mae Lide				
19a. Informant's Name/Relationship (Type, Print) Annie Mae Harrison				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2405 Bennett Dr Darlington S.C. 29532				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. Location - City or Town, State 10-14-00 Beltsville Md		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Sterling Funeral Service 1601 Kenilworth Ave NE Wash DC 20019				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. DILATED CARDIOMYOPATHY Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) M		28b. Time of Injury 11:00 AM		
28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) SEPTEMBER 17, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) OCT 23 2000				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35738

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HENRY SOMMER				2. Date of Death Month Day Year OCTOBER 21, 2000				3. Time of Death 5:27AM	
	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				4b. City, Town, or Location of Death ANNAPOLIS				4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 577-24-3383		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 29, 1919		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD.		10b. County ANNE ARUNDEL		10c. City, Town or Location GAMBRILLS				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 2541 DAVIDSONVILLE ROAD				10f. Zip Code 21054		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates 1944-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+) -0-				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARPENTER			16b. Kind of Business/Industry UNION LOCAL #132		
	17. Father's Name (First, Middle, Last) JOHN J. SOMMER				18. Mother's Name (First, Middle, Maiden Surname) PHILOMENA BOTTNER					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) ELSIE M. SOMMER/ SPOUSE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS 10e					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LAKEMONT MEMORIAL GARDENS		Date OCT. 24, 2000		20c. Location - City or Town, State DAVIDSONVILLE, MD.			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME 16000 ANNAPOLIS RD., BOWIE, MD. 20715					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) a. <i>hypertension / cardiac arrest</i> min. Due to (or as a consequence of) b. <i>GI bleed / anemia</i> hrs. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { c. <i>coronary artery disease</i> years Due to (or as a consequence of) d.								Approximate interval between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>dementia</i> <i>hypothyroidism</i>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D19180		29d. Date signed (Month, Day, Year) 10/21/00			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wm A Cassidy 171 Defense Hwy Annapolis 21401									
	31. Date filed (Month, Day, Year) OCT 23 2000				32. Registrar's Signature <i>[Signature]</i>					

ORIGINAL

Handwritten signature or initials.

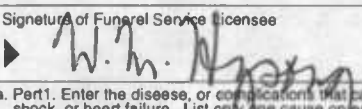

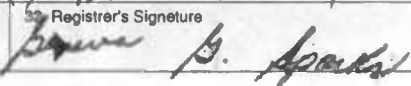
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35739

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUTH E. SCHAD				2. Date of Death Month Day Year OCT. 20, 2000		3. Time of Death 1940	
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 217-14-9606	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) APR. 2, 1918		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MD.		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 9701- VEIRS DRIVE				10f. Zip Code 20850		10g. Citizen of What Country? USA		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) SECRETARIAL				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARIAL			16b. Kind of Business/Industry NOT AVAILABLE	
17. Father's Name (First, Middle, Last) JOHN F. SCHAD				18. Mother's Name (First, Middle, Maiden Surname) ANNA LILLIAN BERTRAM				
19a. Informant's Name/Relationship (Type, Print) REV. DR. REICHARD- EXECUTOR				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9701- VEIRS DR., ROCKVILLE, MD. 20850				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LORRAIN PARK CEM.		Date 10/25		20c. Location - City or Town, State BALTIMORE, MD.		
21. Signature of Funeral Service licensee 				22. Name and Address of Facility Hysong Co., Inc. 1300- N St., Nw. Wash., DC				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Urosepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Dementia						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D39934		29d. Date signed (Month, Day, Year) October 21, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN T. COULTER, MD, 15201 Shady Grove Road #202, Rockville, MD 20852								
31. Date filed (Month, Day, Year) OCT 24 2000		32. Registrar's Signature 						

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35740

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Catherine M. Smith				2. Date of Death Month 10 Day 17 Year 2000				3. Time of Death 12:18PM		
	4a. Facility Name (If not institution, give street and number) Regency Nursing Home				4b. City, Town, or Location of Death Forestville				4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 249-40-6432		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) 05-30-29		9. Birthplace (State or Foreign Country) South Carolina		
	10a. State D.C.		10b. County		10c. City, Town or Location Washington, DC				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1524 Gales Street, NE				10f. Zip Code 20002				10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook				16b. Kind of Business/Industry Private			
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) Roxie Corbitt							
19a. Informant's Name/Relationship (Type, Print) Floyd E. Smith/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1524 Gales Street, NE, Washington DC 20002							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		20c. Date 10/23/00		20d. Location - City or Town, State Brentwood, MD			
21. Signature of Funeral Service Licensee <i>Prince Edwards</i>				22. Name and Address of Facility Hodges and Edwards Funeral Home 3910 Silver Hill Road, Suitland MD 20746							
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Metastatic Carcinoma of the Lung Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>George C. Hagar, Jr.</i>				29c. License number 039550		29d. Date signed (Month, Day, Year) 10-20-00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George C. Hagar, Jr. M.D. 4850 Forbes Blvd Lanham, Md 20706											
31. Date filed (Month, Day, Year) OCT 24 2000				32. Registrar's Signature <i>George C. Hagar, Jr.</i>							

ORIGINAL

22



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35741

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Susanna E. Satterfield				2. Date of Death Month: October Day: 21 Year: 2000		3. Time of Death 1:30 p.m.	
	4a. Facility Name (If not institution, give street and number) Doctor's Community Hospital				4b. City, Town, or Location of Death Lanham		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 165-24-7940		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) July 22, 1910	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location College Park	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 8007 Travis Lane		10f. Zip Code 20740		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry American Heart Fund		17. Father's Name (First, Middle, Last) John Shirey		
18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Horner		19a. Informant's Name/Relationship (Type, Print) David Satterfield - Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8007 Travis Lane, College Park, Maryland 20740		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) Freidens Church Cemetery		20c. Location - City or Town, State Freidens, Pa. 15541		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		a. Respiratory Failure Due to (or as a consequence of):		Approximate Interval Between Onset and Death Wk-Month		b. Coma Due to (or as a consequence of):		
c. Hypertension Due to (or as a consequence of):		d. Dementia Due to (or as a consequence of):		Day-Wk		Years		
Month-Year		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Osteoporosis and Squamous Cell Carcinoma of Head		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		
29c. License number D-34525		29d. Date signed (Month, Day, Year) 10-23-2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S-J-KAO, MD - 4000 Mitchellville Road, #220, Bowie MD - 20716		31. Date filed (Month, Day, Year) OCT 24 2000		
32. Registrar's Signature 		State Registrar		DHMH 16 Rev 6/95		ORIGINAL		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

RONALD

State of Maryland / Department of Health and Mental Hygiene

00 35742

SPANGLER 11/14/00 yf
amend item 23a, 27, 28a, b, c, d, f, e per me G789 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ronald Peter Spangler				2. Date of Death Month Day Year NOVEMBER 4, 2000				3. Time of Death 10:25 A.M.	
	4a. Facility Name (If not institution, give street and number) HARFORD MEMORIAL HOSPITAL				4b. City, Town, or Location of Death HAVRE DE GRACE				4c. County of Death HARFORD	
Funeral Director	5. Social Security Number 213-68-4636		6. Sex XX M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	Usual Residence of Decedent		8. Date of Birth (Month, Day, Year) June 18, 1955		9. Birthplace (State or Foreign Country) Germany					
10a. State MD		10b. County Harford		10c. City, Town or Location Aberdeen				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 3825 West Chapel Road				10f. Zip Code 21001				10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Test Driver				16b. Kind of Business/Industry U.S. Government		
17. Father's Name (First, Middle, Last) Donald R. Spangler				18. Mother's Name (First, Middle, Maiden Surname) Erna Groschalczak						
19a. Informant's Name/Relationship (Type, Print) stephanie A. Spangler (Spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3825 W. Chapel Rd., Aberdeen, MD 21001						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) R. A. Ferris & Co., Inc.				20c. Location - City or Town, State 11/9/00 West Chester, PA		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A.				Aberdeen, Maryland 21001-3399		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC INTOXICATION Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) found: 11/4/00		28b. Time of Injury 9:30 A M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred unknown		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence				28f. Location (Street and Number or Rural Route Number, City or Town, State) 3825 West Chapel Rd., Aberdeen, MD.						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number O.C.M.E.		
				29d. Date signed (Month, Day, Year) NOVEMBER 5, 2000						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARYSMITH P. KORON				111 Penn Street, Baltimore, Maryland 21201						
State Registrar		31. Date filed (Month, Day, Year) NOV 09 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ASP
amend item 23a,27, per me G789 11/16/00 yf

State of Maryland / Department of Health and Mental Hygiene

00 35743

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Wallace Talcott				2. Date of Death Month Day Year OCTOBER 30 2000		3. Time of Death 0658	
	4a. Facility Name (If not institution, give street and number) 5550 TUCKERMAN LANE			4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 218-03-3570	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) October 8, 1912	9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Rockville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 1705 Glastonberry Road			10f. Zip Code 20854		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electromechanical Engineer		16b. Kind of Business/Industry U.S. Navy			
	17. Father's Name (First, Middle, Last) John J. Talcott			18. Mother's Name (First, Middle, Maiden Surname) Nellie Ritchie Payne				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Jan Provost / Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1705 Glastonberry Rd. Rockville, MD 20854				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery November 3, 2000 Brentwood, MD		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722					
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
				24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) OCTOBER 31, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J-LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) NOV 02 2000		32. Registrar's Signature 						

jhm
FREDDIE L
TAYLOR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35744

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FREDDIE LEE TAYLOR				2. Date of Death Month Day Year OCTOBER 20, 2000		3. Time of Death 20:44 PM	
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER				4b. City, Town, or Location of Death Cheverly		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 229-50-3892	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 14, 1940		9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Landover		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 2201 Columbia Avenue				10f. Zip Code 20785		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2 Years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Boiler Plant Foreman		16b. Kind of Business/Industry Government		
17. Father's Name (First, Middle, Last) Robert Lee Taylor, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Missouri Ann Graves				
19a. Informant's Name/Relationship (Type, Print) Agnes E. Taylor/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2201 Columbia Avenue, Landover, Maryland 20785				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Ceme.		Date 10/27 2000		20c. Location - City or Town, State Cheltenham, Maryland		
21. Signature of Funeral Service Licensee Nancy A. Perentis				22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Nancy A. Perentis, M.D.				29c. License number OCME		29d. Date signed (Month, Day, Year) OCTOBER 21, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) OCT 24 2000		32. Registrar's Signature Bernice B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35745

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clara Elizabeth Taylor				2. Date of Death Month Day Year October 23, 2000		3. Time of Death 4:00AM	
	4a. Facility Name (If not institution, give street and number) Civista Medical Center				4b. City, Town, or Location of Death LaPlata		4c. County of Death Charles	
Funeral Director	5. Social Security Number 579-42-9548	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 13, 1935		9. Birthplace (State or Foreign Country) Washington DC
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Charles	10c. City, Town or Location LaPlata			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 5036 Skylark Drive				10f. Zip Code 20646		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Home		
	17. Father's Name (First, Middle, Last) Jeremiah Courtney				18. Mother's Name (First, Middle, Maiden Surname) Margaret Sherriff			
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Richard Lee Taylor (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4930 Cloverdale Ct. LaPlata, Maryland 20646			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Memorial Gardens		20c. Location - City or Town, State Waldorf, Maryland		20d. Date Oct. 26, 2000	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. LUNG CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						Approximate Interval Between Onset and Death 3 WEEKS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D 28281		29d. Date signed (Month, Day, Year) 10/23/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NELSON BENTERS, 8926 WOODYARD RD, CLINTON, MD 20735								
31. Date filed (Month, Day, Year) OCT 25 2000		32. Registrar's Signature 						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35746

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Fletcher Pearre Veitch

2. Date of Death

Month Day Year
October 22, 2000

3. Time of Death

10:55 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

St. Mary's Nursing Center

4b. City, Town, or Location of Death

Leonardstown

4c. County of Death

St. Mary's

5. Social Security Number

578-03-4224

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 21, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Lexington Park

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

P.O. Box 513

10f. Zip Code

20653

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Biochemist

16b. Kind of Business/Industry

University of MD

17. Father's Name (First, Middle, Last)

Fletcher Pearre Veitch, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Laura Boyle

19a. Informant's Name/Relationship (Type, Print)

Fletcher P. Veitch, III - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

29711 Dogwood Circle, Mechanicsville, MD 20659

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

10/24/00

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I - Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.

Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Chronic Lymphocytic Leukemia

Due to (or as a consequence of):

b. Cellulitis Left heel

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending
Investigation☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D34539

29d. Date signed (Month, Day, Year)

October 23, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khalid M. Husian, M.D., 22576 McArthur Boulevard, California, MD 20619

31. Date filed (Month, Day, Year)

OCT 24 2000

32. Registrar's Signature

Benjamin S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35747

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Katherine Wilburn</i>				2. Date of Death Month <i>Oct</i> Day <i>24</i> Year <i>2000</i>				3. Time of Death <i>6 PM</i>			
	4a. Facility Name (If not institution, give street and number) <i>Southern Maryland Hospital</i>				4b. City, Town, or Location of Death <i>Clinton</i>				4c. County of Death <i>Prince Georges</i>			
Funeral Director	5. Social Security Number <i>185-30-1465</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>89</i> Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) <i>Oct 2 1911</i>			
	9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>		10a. State <i>MD</i>		10b. County <i>Prince George's</i>		10c. City, Town or Location <i>Upper Marlboro</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Usual Residence of Decedent												
10e. Street and Number <i>12722 Richland Place</i>				10f. Zip Code <i>20772</i>				10g. Citizen of What Country? <i>U.S.A.</i>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11th</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Housewife</i>				16b. Kind of Business/Industry <i>Domestic</i>				
17. Father's Name (First, Middle, Last) <i>Frank Wilson</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>Ella Carr</i>							
19a. Informant's Name/Relationship (Type, Print) <i>Ellen J. Brinson/Daughter</i>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>12722 Richland Pl. Upper Marlboro, MD. 20772</i>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Harmony Memorial Park</i>			Date <i>10/30/00</i>		20c. Location - City or Town, State <i>Landover, MD.</i>				
21. Signature of Funeral Service Licensee <i>Betha J. Gentry</i>					22. Name and Address of Facility <i>J.B Jenkins Funeral Home</i> <i>7474 Landover Rd. Landover, MD. 20785</i>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>stroke</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											Approximate Interval Between Onset and Death <i>day 5</i>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i>												
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>[Signature]</i>			29c. License number <i>D24352</i>			29d. Date signed (Month, Day, Year) <i>Oct 25 2000</i>			
30. Name and address of person who completed cause of death (Item 29a) (Type, Print) <i>O Hage 9131 Piscataway Rd Clinton Md</i>												
31. Date filed (Month, Day, Year) <i>OCT 27 2000</i>			32. Registrar's Signature <i>[Signature]</i>									

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 35748

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Louise Whitehead				2. Date of Death Month Day Year October 21 2000				3. Time of Death 11:00AM						
	4a. Facility Name (If not Institution, give street and number) 14220 North Gate Drive				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery						
Funeral Director	5. Social Security Number 578-62-0958	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 28, 1909		9. Birthplace (State or Foreign Country) Mississippi							
	Usual Residence of Decedent														
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
10e. Street and Number 14220 North Gate Drive				10f. Zip Code 20906		10g. Citizen of What Country? United States									
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher			16b. Kind of Business/Industry D.C. Public Schools								
17. Father's Name (First, Middle, Last) Charles Hairston				18. Mother's Name (First, Middle, Maiden Surname) Charity Hairston											
19a. Informant's Name/Relationship (Type, Print) Marilyn Wescott - Granddaughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14220 North Gate Dr., Silver Spring, MD 20906											
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lee's Crematory		Date 10/28/2000		20c. Location - City or Town, State Clinton, MD							
21. Signature of Funeral Service Licensee John T. Stewart, III				22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. ISCHEMIC HEART DISEASE Due to (or as a consequence of): c. HYPERTENSION Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death HOURS YEARS YEARS					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier [Signature]		29c. License number D25947		29d. Date signed (Month, Day, Year) OCTOBER 25, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Evelyn Jackson, MD 346 CLANDWOOD COURT, SUITE 100, OLNEY, MD 20852															
31. Date filed (Month, Day, Year) OCT 27 2000				32. Registrar's Signature [Signature]											

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 35749

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edith A. Woods				2. Date of Death Month Day Year OCTOBER 17 2000		3. Time of Death 6:20P.M.	
	4a. Facility Name (If not institution, give street and number) CIVISTA MEDICAL CENTER				4b. City, Town, or Location of Death LA PLATA		4c. County of Death CHARLES	
Funeral Director	5. Social Security Number 577-28-3542	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 1, 1920		9. Birthplace (State or Foreign Country) Washington DC
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's		10c. City, Town or Location Camp Springs		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 5513 Magruder Avenue				10f. Zip Code 20748		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dietician		16b. Kind of Business/Industry Board of Education			
	17. Father's Name (First, Middle, Last) James McKim V				18. Mother's Name (First, Middle, Maiden Surname) Olive Ogden			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Jim Shanabrook (Nephew)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8381 Lockwood Road Pasadena, Maryland 21122			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory		Data October 20, 2000		20c. Location - City or Town, State Clinton, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, Maryland 20735			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Respiratory Failure Due to (or as a consequence of): b. Aspiration Pneumonia Due to (or as a consequence of): c. Sepsis Due to (or as a consequence of): d. Myeloproliferative disorder							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration, Stroke, Liver Cirrhosis HTN, NIDDM						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  M.D.		29c. License number D0053219		29d. Date signed (Month, Day, Year) 10-18-2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZAFAR A. ANSARI M.D. 7E POST OFFICE ROAD WALDORF MARYLAND 20602								
31. Date filed (Month, Day, Year) OCT 25 2000		32. Registrar's Signature 						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35750

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jonathan Lynn Walker				2. Date of Death Month Day Year OCTOBER 24, 2000				3. Time of Death 11:45 P.M.						
	4a. Facility Name (If not institution, give street and number) 2800 BLOCK TUCKER ROAD				4b. City, Town, or Location of Death FORT WASHINGTON				4c. County of Death PRINCE GEORGE'S						
Funeral Director	5. Social Security Number 577-04-8614		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 20 Yrs.		8. Date of Birth Month Day Year 08/27/80		9. Birthplace (State or Foreign Country) Washington, DC						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State MD		10b. County Prince George's		10c. City, Town or Location Fort Washington				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	10e. Street and Number 2102 Walf Street; Ft. Washington, MD				10f. Zip Code 20744		10g. Citizen of What Country? USA								
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student				16b. Kind of Business/Industry Education						
	17. Father's Name (First, Middle, Last) Howard Lynn Walker				18. Mother's Name (First, Middle, Maiden Surname) Latanya Michelle										
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Latanya Michelle Walker				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2102 Walf Street; Ft. Washington, MD 20744										
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Cemetery		Date 10-28-00		20c. Location - City or Town, State Landover, Maryland								
	21. Signature of Funeral Service Licensee Wanda C. Bacon CCO 341				22. Name and Address of Facility Bacon Funeral Home, Inc. 3447 14th St., N.W.; Washington, D.C. 20010										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE											
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month/Day Year) Found 10-24-00		28b. Time of Injury Found 2337 P M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred motorcycle accident							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street				28f. Location (Street and Number or Rural Route Number, City or Town, State) Rock & Turner Rd Fort Washington, Md											
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier Dennis J. Chuteau		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) OCTOBER 25, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J Chuteau 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) OCT 26 2000		32. Registrar's Signature B. B. Jones													

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Ida Mae Williams		2. Date of Death Month Day Year October 13, 2000		3. Time of Death 2:30PM	
4a. Facility Name (If not institution, give street and number) Heartland Health Care Center		4b. City, Town, or Location of Death Hyattsville		4c. County of Death Prince Georges'	
5. Social Security Number 217-16-0017		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.	
8. Date of Birth (Month, Day, Year) April 16, 1916		9. Birthplace (State or Foreign Country) South Carolina			
Usual Residence of Decedent					
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Springdale	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 3514 Jeff Road		10f. Zip Code 20774		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) (Unknown) Perkins		18. Mother's Name (First, Middle, Maiden Surname) Addie Kenner			
19a. Informant's Name/Relationship (Type, Print) Albert L. Williams/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3514 Jeff Road, Springdale, Maryland 20774			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Location - City or Town, State Brentwood, Maryland	
20d. Date 10/21/2000					
21. Signature of Funeral Service Licensee Nancy A. Perente		22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonary Embolism Due to (or as a consequence of): Cerebrovascular Accident-Left Ant-Cerebral Artery Hypertension Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death Less than 30 Minutes 3 Months			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonitis- Left lower lobe Hypothyroidism		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier [Signature]		29c. License number 017682		29d. Date signed (Month, Day, Year) 10-13-2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Gaithersburg Medical Center OLUFUNSHO O. FAMUYIWA, 501 N. Frederick Road, Gaithersburg, MD 20877					
31. Date filed (Month, Day, Year) OCT 23 2000		32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35752

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) OTTO WALTER WILLIAMS				2. Date of Death Month Day Year OCTOBER 17, 2000		3. Time of Death 9:40 PM	
	4a. Facility Name (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL				4b. City, Town, or Location of Death LANHAM		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 216-14-8917		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F XX		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 24, 1918	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County P.G.		10c. City, Town or Location Largo	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 12805 Cambleton Drive		10f. Zip Code 20774	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Administrator				16b. Kind of Business/Industry Government		17. Father's Name (First, Middle, Last) Vandellia Williams	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Hattie Brown				19a. Informant's Name/Relationship (Type, Print) Ada F. Williams/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12805 Cambleton Drive, Largo Md. 20774	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematorium or other place) Arlington National Cem		20c. Location - City or Town, State Arlington, Va.	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Nancy A. Perenti				22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd., Landover Md. 20785			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARRHYTHMIA Due to (or as a consequence of): b. PNEUMONIA Due to (or as a consequence of): c. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 5 minutes 36 days 10 months			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION CORONARY ARTERY DISEASE				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Shulaw M.D.			
	29c. License number D47604				29d. Date signed (Month, Day, Year) 10/18/00			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOBHAN MATHEW, M.D., 2905 MITCHELLVILLE RD. #104, Bowie, MD 20716				31. Date filed (Month, Day, Year) OCT 23 2000			
	32. Registrar's Signature B. S. Smith				33. Registrar's Name B. S. Smith			

ORIGINAL

Handwritten text, possibly a signature or initials, located in the center of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35753

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VICTORIA ANN WELBORNE				2. Date of Death Month Day Year October 20 2000		3. Time of Death 10:37 PM	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 218-30-3294		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) March 15, 1922	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location North Brentwood	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 3923 Allison Street		10f. Zip Code 20722		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Housekeeper		16b. Kind of Business/Industry Government				
17. Father's Name (First, Middle, Last) Phillip Butler				18. Mother's Name (First, Middle, Maiden Surname) Frances Barnes				
19a. Informant's Name/Relationship (Type, Print) Sherri V. Austin/Grand-daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5523 Glen Avenue, Lanham, Maryland 20706				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Location - City or Town, State Landover, Maryland		20d. Date 10/24 2000		
21. Signature of Funeral Service Licensee Nancy A. Pasanti		22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTERENAL FALIURE Due to (or as a consequence of): ACUTE PULMONARY EDEMA Due to (or as a consequence of): ACUTE RESPIRATORY FALIURE Due to (or as a consequence of): MITRAL REGURGITATION		Approximate Interval Between Onset and Death 1 WEEK 3 DAYS 1 DAY 1 WEEK						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION ANEMIA				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier V. Singh Attend Phys		29c. License number 019897		29d. Date signed (Month, Day, Year) 10.21.00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. SINGH 7209 A HANOVER PARKWAY GREENBELT MD20770								
31. Date filed (Month, Day, Year) OCT 23 2000		32. Registrar's Signature Beverly B. Sparks						

ORIGINAL

1942-1943

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

George Yamoah

2. Date of Death

Oct. 18 2000

3. Time of Death

12:30 AM

4a. Facility Name (If not institution, give street and number)

Fort Washington Hospital

4b. City, Town, or Location of Death

Fort Washington Prince Georges

4c. County of Death

5. Social Security Number

578-76-8661

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

51

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 14 1949

9. Birthplace (State or Foreign Country)

Ghana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6802 Elbrook Dr.

10f. Zip Code

20706

10g. Citizen of What Country?

Ghana

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cab Driver

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

Isaac C. Yamoah

18. Mother's Name (First, Middle, Maiden Surname)

Abena Achiaa

19a. Informant's Name/Relationship (Type, Print)

Samuel Nsiah (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6802 Elbrook Dr. Lanham, MD 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bethel Cemetery

Date

11/18/00

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rendon/Hale Funeral Home

9013 Annapolis Rd. Lanham, MD 20706

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Metastatic Carcinoma.*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Bronchogenic Cancer.*
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0042955

29d. Date signed (Month, Day, Year)

10/18/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edgar Potter 1328 Southern Ave. #210 Washington, D.C. 20032

31. Date filed (Month, Day, Year)

OCT 26 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

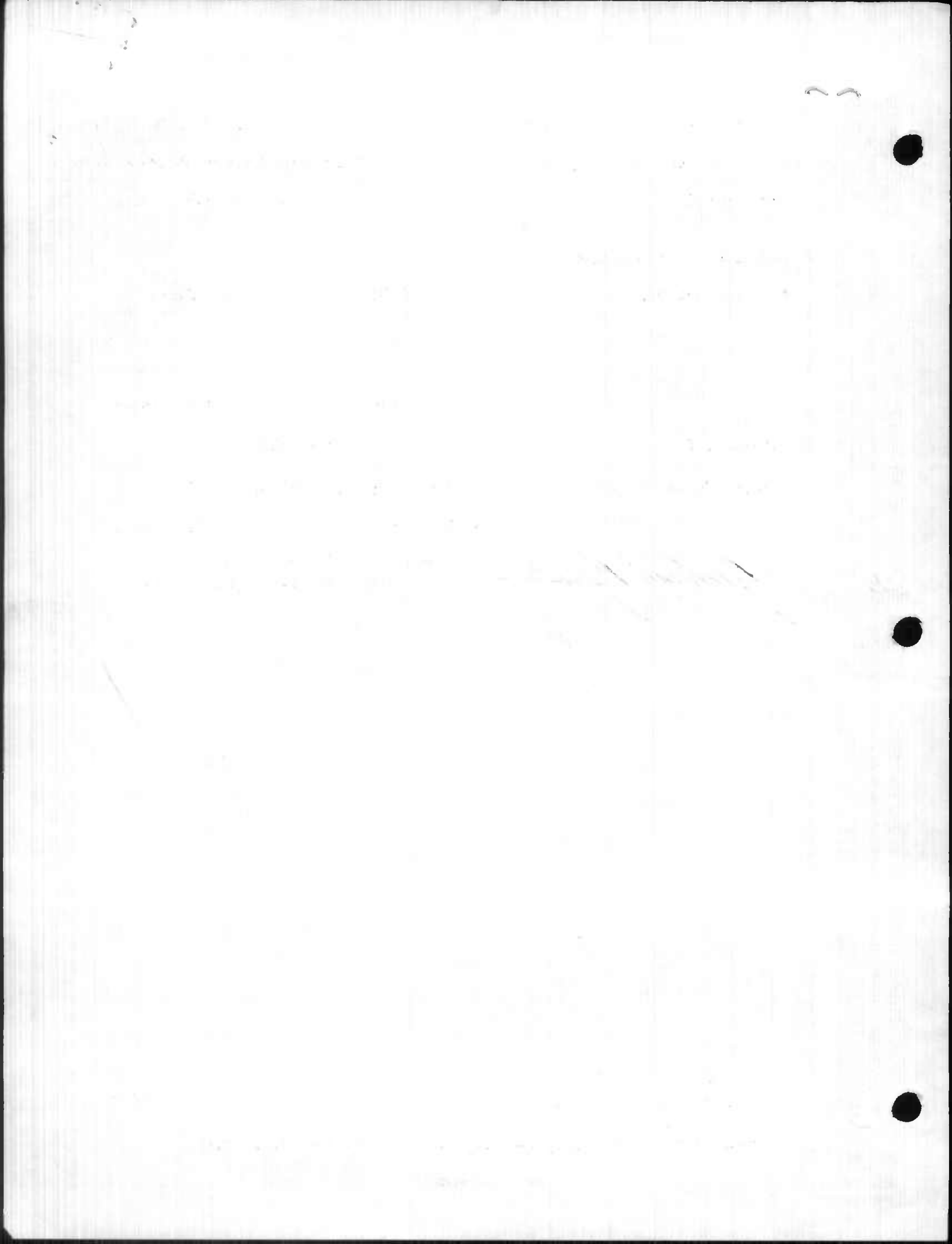
Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35755

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KENNETH HOWARD ANDREW ANDERSON				2. Date of Death Month Nov Day 3 Year 2000		3. Time of Death 3:15 PM	
	4a. Facility Name (If not institution, give street and number) GILCHREST NURSING CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-56-4058	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) Nov. 10, 1950		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3507 Elmley Ave				10f. Zip Code 21213		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 year College (1-4 or 5+) LABORER				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER			16b. Kind of Business/Industry Private Industry	
17. Father's Name (First, Middle, Last) ANDREW JENKINS				18. Mother's Name (First, Middle, Maiden Surname) PAULINE CAREY				
19a. Informant's Name/Relationship (Type, Print) Dorothy Soris is / Companion				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3507 Elmley Ave Baltimore, Md 21213				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) ARMISTE Memorial Park		20c. Location - City or Town, State Armistee, Maryland		Date 11/9/2000
21. Signature of Funeral Service Licensee Dorothy Soris				22. Name and Address of Facility CHATHAM HALL F.N. 5240 REISTERSTOWN ROAD Baltimore, Md 21215				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) multiple myeloma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Hypertension Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) HOSPICE				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Dorothy Soris MD				29c. License number 00051926		29d. Date signed (Month, Day, Year) November 5, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen M. Gordon 6601 N. Charles St. Baltimore MD 21204								
31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature [Signature]				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35756

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George Altmeyer

2. Date of Death
Month Day Year
November 7 20003. Time of Death
11:30PM

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

218-09-2415

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 21 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3 Baratra Court #201

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

Joseph Altmeyer

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Shultz

19a. Informant's Name/Relationship (Type, Print)

Mrs. Gertrude Altmeyer/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 Baratra Court #201 Timonium, Md. 21093

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Crestlawn Cemetery

Date

11-10-00

20c. Location - City or Town, State

Marriottsville, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. RENAL FAILURE

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☒ Other (Specify) HOSPICE

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending

Investigation

☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

043725

29d. Date signed (Month, Day, Year)

11/8/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

Benjamin S. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NOVEMBER 7, 2000 11:30 p.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

GEORGE ALTMAYER

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35757

Amended Item#30 perABG789 11/13/2000 EV

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) V. PATRICIA ALLAN				2. Date of Death Month Day Year OCTOBER 30, 2000				3. Time of Death 1:30 AM	
	4a. Facility Name (If not institution, give street and number) 205 Brown Branch Farm Lane				4b. City, Town, or Location of Death Church Hill				4c. County of Death Queen Annes	
Funeral Director	5. Social Security Number 433-33-8423		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 75		8. Date of Birth (Month, Day, Year) Mar 1, 1925		9. Birthplace (State or Foreign Country) Canada	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Queen Annes		10c. City, Town or Location Church Hill				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 205 Brown Branch Farm Lane				10f. Zip Code 21623		10g. Citizen of What Country? Canada			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) housewife				16b. Kind of Business/Industry none			
	17. Father's Name (First, Middle, Last) Ernest J. T. Hayes				18. Mother's Name (First, Middle, Maiden Surname) Helen E. Ross					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Jennifer Welsh/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Broadway Ave Toronto Ontario, Canada M4G 2R7					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Date		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. liver failure b. Metastatic Fallopian Tube Carcinoma Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier Heather Morphy				29c. License number D0054890				29d. Date signed (Month, Day, Year) 11/1/00	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Heather Morphy 6602 Church Hill rd Suite 200 Chestertown, Md 21620									
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature James S. Sparks								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35758

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VIRGINIA HALL ALDRIDGE				2. Date of Death Month November Day 8 , Year 2000		3. Time of Death 10:30 A.M.	
	4a. Facility Name (If not institution, give street and number) Presbyterian Home of Maryland				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 219-42-6256	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 2, 1911		9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 400 Georgia Court				10f. Zip Code 21204		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Claims Examiner		16b. Kind of Business/Industry Government	
	17. Father's Name (First, Middle, Last) Stanley Alexander Hall				18. Mother's Name (First, Middle, Maiden Surname) Nannie McDonald Bragg			
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Rolfe T. Aldridge, Jr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8000 Old Harford Road Baltimore, Maryland 21234			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 11-11-00		20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee <i>George J. Ferraro</i>				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Colon carcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Attending MD</i>				29c. License number 037016		29d. Date signed (Month, Day, Year) November 8, 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Kenneth M. Greene, MD 6701 N. Charles St, Suite 4105 Baltimore, MD 21204								
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature <i>Sparks</i>						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35759

AMENDED ITEMS# 23& 27 per ME G792 022101 SS

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Raymond A. Alston			2. Date of Death Month Day Year October 31 2000		3. Time of Death 11:56 A.M.	
	4a. Facility Name (If not institution, give street and number) Howard County General Hospital			4b. City, Town, or Location of Death Columbia		4c. County of Death Howard	
Funeral Director	5. Social Security Number 216-76-7438	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 43 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year May 25, 1957	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 2561 Hollins St.		10f. Zip Code 21223		10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. African American
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Private Co.		
	17. Father's Name (First, Middle, Last) John L. Alston			18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Bennett			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Elizabeth Alston (Mother)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2561 Hollins St. Balto. Md. 21223			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion		20c. Location - City or Town, State Lansdowne, Md.		Approximate Interval Between Onset and Death
	21. Signature of Funeral Service Licensee Joseph L. Russ		22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
	Immediate Cause (Final disease or condition resulting in death) a. SEPSIS AND DEHYDRATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number O.C.M.E.					
29b. Signature and title of certifier Theodore M. King		29d. Date signed (Month, Day, Year) November 1, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35760

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Ida</u>		2. Date of Death Month <u>November</u> Day <u>7</u> Year <u>2000</u>		3. Time of Death <u>04:02AM</u>
	4a. Facility Name (If not institution, give street and number) <u>The Johns Hopkins Hospital</u>		4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death <u>NA</u>
Funeral Director	5. Social Security Number <u>218-42-9078</u>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>55</u> Yrs.	8. Date of Birth (Month, Day, Year) <u>11-26-44</u>	9. Birthplace (State or Foreign Country) <u>SC</u>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <u>MD</u>	10b. County <u>NA</u>	10c. City, Town or Location <u>Baltimore</u>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <u>805 N. Streeper Street</u>		10f. Zip Code <u>21205</u>		10g. Citizen of What Country? <u>USA</u>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>9th Grade</u> College (1-4 or 5+) <u>NA</u>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Presser</u>
	17. Father's Name (First, Middle, Last) <u>Charlie Moses</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Ella Player</u>		19. Informant's Name/Relationship (Type, Print) <u>Lamont Brown</u>
Physician /Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3522 Mayfield Avenue Baltimore, Maryland 21205</u>		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
	20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Voshell Mem. Gardens 11-11-2000 Dundalk, MD</u>		20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>Baltimore, Maryland 21202</u> <u>WM.C.March FH 1101 E.North Avenue</u>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. Acute Myocardial Infarction</u>				
	Due to (or as a consequence of): b. _____ c. _____ d. _____				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28. Date of Injury (Month, Day Year) _____ 28b. Time of Injury _____ M _____ 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <u>[Signature] MD</u>		29c. License number <u>RES-000</u>		29d. Date signed (Month, Day, Year) <u>November 7, 2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>GK Bruce 600 N. Wolfe Street Baltimore MD 21287</u>					
31. Date filed (Month, Day, Year) <u>NOV 13 2000</u>		32. Registrar's Signature <u>[Signature]</u>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35761

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret C. Balle				2. Date of Death Month Day Year Nov. 8, 2000		3. Time of Death 12:20PM	
	4a. Facility Name (If not institution, give street and number) Stella Maris				4b. City, Town, or Location of Death Timonium		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 065-03-9504		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 14, 1918	
	9. Birthplace (State or Foreign Country) NY		10a. State MD		10b. County Baltimore		10c. City, Town or Location Towson	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 7925 York Road		10f. Zip Code 21204		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A		16b. Kind of Business/Industry Typist		16c. Kind of Business/Industry Security	
	17. Father's Name (First, Middle, Last) David J. Doyle				18. Mother's Name (First, Middle, Maiden Surname) Margaret C. McAllister			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Kathryn A. Sadowski/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Brooking Ct. Timonium, MD 21093			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Washington Crematory		20c. Location - City or Town, State Laurel, MD		20d. Date Nov. 9, 2000	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Director Michael J. Flagle				22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): b. Seizure disorder Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 1 Year			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Acrema				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier S. Ammer				29c. License number D30641		29d. Date signed (Month, Day, Year) November 9 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMESH SABAPATHI 3400 ELDON AVENUE BALTIMORE MD 21253							
State Registrar	31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature Benjamin B. Sparks			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35762

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUTH DOLORES WREN-BROWN				2. Date of Death Month NOVEMBER Day 12 Year 2000		3. Time of Death 0614	
	4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 212-20-6704		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) SEPT. 29, 1922	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 5308 THE ALAMEDA		10f. Zip Code 21239		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 yrs College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) EDITOR		16b. Kind of Business/Industry MICHELLE PUBLISHING CO.			
	17. Father's Name (First, Middle, Last) ROBERT WREN				18. Mother's Name (First, Middle, Maiden Surname) HILDA GROSS			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) WILLIE ADAMS (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 378 JAMIE COURT, GLEN BURNIE, MD. 21060			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LODGE PARK CEMETERY		20c. Location - City or Town, State 11-16-00 GLEN BURNIE, MARYLAND		21. Signature of Funeral Service Licensee JOSEPH H. BROWN JR. FUNERAL HOME	
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility 2170 N. FULTON AVE. BALTO, MD. 21217				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PNEUMONIA Due to (or as a consequence of): PARKINSON'S DISEASE Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 15 YEARS			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	29b. Signature and title of certifier Raymond Taylor MD				29c. License number D37370		29d. Date signed (Month, Day, Year) 11/12/00	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAYMOND TAYLOR MD UNION MEMORIAL HOSPITAL				31. Date filed (Month, Day, Year) NOV 13 2000			
	32. Registrar's Signature B. Sparks				33. State Registrar NOV 13 2000			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35763

Amended Item#9 per FHG789 11/13/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Congress W Brooks</i>				2. Date of Death Month <i>November</i> Day <i>14</i> Year <i>00</i>				3. Time of Death <i>0953</i>	
	4a. Facility Name (If not institution, give street and number) <i>2 GOOD SAMARITAN Hosp</i>				4b. City, Town, or Location of Death <i>BALT</i>				4c. County of Death <i>BALT</i>	
Funeral Director	5. Social Security Number <i>220 246694</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>71</i> Yrs.		8. Date of Birth Month, Day, Year <i>10/20/29</i>		9. Birthplace (State or Foreign Country) <i>MD. US</i>	
	Usual Residence of Decedent									
10a. State <i>MD</i>		10b. County <i>NA</i>		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <i>2617 Ailsa Ave</i>				10f. Zip Code <i>21214</i>				10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>Unknown</i> College (1-4 or 5+) <i>na</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Truck Driver</i>				16b. Kind of Business/Industry <i>Trucking Company</i>		
17. Father's Name (First, Middle, Last) <i>Congress Brooks</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Flossie Dale</i>						
19a. Informant's Name/Relationship (Type, Print) <i>Regina Thomas Belin-Sister</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4021 Bereva Road, Baltimore Md 21215</i>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Garrison Forest Vet.</i>				20c. Location - City or Town, State <i>11/14/00 Owings Mills, Md</i>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>March F/H West</i> <i>4300 Wabash Ave, Baltimore Md 21215</i>						
23. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death) a. <i>Myocardial Infarction</i> Due to (or as a consequence of):										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):										
c. Due to (or as a consequence of):										
d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Suresh K. Tripathi</i>				29c. License number <i>D 30661</i>				29d. Date signed (Month, Day, Year) <i>November 10th 2000</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Suresh K. Tripathi</i> <i>5601 Loch Raven Blvd, Baltimore Md - 21239</i>										
31. Date filed (Month, Day, Year) <i>NOV 13 2000</i>		32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35764

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Phyllis N. Brown		2. Date of Death Month Day Year NOVEMBER 09, 2000		3. Time of Death 02:27 A.M.	
	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-52-0501		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.	
	8. Date of Birth (Month, Day, Year) 06 12 49		9. Birthplace (State or Foreign Country) M.D.			
To Be Completed by Funeral Director	Usual Residence of Decedent					
	10a. State MD		10b. County Baltimore		10c. City, Town or Location Parkville	
	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	10e. Street and Number 3 Ashlar Hill Ct.		10f. Zip Code 21234		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: Black					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) 4yrs		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrator		16b. Kind of Business/Industry Living Word Christian Center	
	17. Father's Name (First, Middle, Last) Eugene P. Brown		18. Mother's Name (First, Middle, Maiden Surname) Mary DeShields			
	19a. Informant's Name/Relationship (Type, Print) Joseph Brown-Brother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 823 Smoketree Road, Pikesville, Md 21208			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		20c. Location - City or Town, State 11/13/00 Randallstown, Md	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
	24a. Was an autopsy performed? INSPECTION 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
Medical Certification: To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined					
State Registrar	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) NOVEMBER 09, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201						
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35765

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DELORES M. BAEHM						2. Date of Death Month Day Year 11 - 02 - 2000			3. Time of Death 1:06 A.M.			
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital						4b. City, Town, or Location of Death Baltimore			4c. County of Death			
Funeral Director	5. Social Security Number 214-20-7146		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Mar 13, 1928	9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent												
10a. State MD		10b. County		10c. City, Town or Location Baltimore						10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 537 Brisbane Road						10f. Zip Code 21229			10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 0						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) executive secretary			16b. Kind of Business/Industry banking				
17. Father's Name (First, Middle, Last) unk						18. Mother's Name (First, Middle, Maiden Surname) unk							
19a. Informant's Name/Relationship (Type, Print) unk						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state						20b. Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee Ronald S. Wade, Director						22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)												hours	
Due to (or as a consequence of):													
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												years	
Due to (or as a consequence of):													
Due to (or as a consequence of):													
Due to (or as a consequence of):													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined						28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier SP Attending Physician						29c. License number D51853			29d. Date signed (Month, Day, Year) November 2, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Silverman, MD 900 Caton Avenue Baltimore 21229													
31. Date filed (Month, Day, Year) NOV 13 2000						32. Registrar's Signature Benjamin B Sparks							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35766

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM R. BURLEY.				2. Date of Death Month Day Year NOV, 8, 2000		3. Time of Death 5:55	
	4a. Facility Name (If not institution, give street and number) BON Secm Hospital.				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 217-07-2278	6. Sex MM 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 06 16 17	9. Birthplace (State or Foreign Country) M.D.	
	Usual Residence of Decedent							
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 107 North Wheeler Ave				10f. Zip Code 21223		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade College (1-4or 5+) na				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry American Standard		
17. Father's Name (First, Middle, Last) Thomas Burley				18. Mother's Name (First, Middle, Maiden Surname) Pearl Queen				
19a. Informant's Name/Relationship (Type, Print) Cleatrice Burley-Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 North Wheeler Ave, Baltimore Md 21223				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crownsville Vet.		Date 11/14/00		20c. Location - City or Town, State Crownsville, Md		
21. Signature of Funeral Service Licensee Gabriele Cook				22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Probable myocardial Infarction Due to (or as a consequence of): b. Congestive heart FAILURE Due to (or as a consequence of): c. Renal Failure Due to (or as a consequence of): d. Exacerbation of chronic obstructive Lung Diseases.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier R. M. Shah M.D.				29c. License number D0019668		29d. Date signed (Month, Day, Year) NOV, 8, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. M. SHAH M.D., BON Secm Hospital, Baltimore. MD.								
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature B Geneva B Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

00-6281-510

00-312

SHARON

BAILEY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35767

amend item 23a,27 per me G790 12/18/00 yf

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SHARON BAILEY				2. Date of Death Month Day Year NOVEMBER 5, 2000				3. Time of Death 4:02P.M.	
	4a. Facility Name (If not institution, give street and number) 151 N. MILTON AVE				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A	
Funeral Director	5. Social Security Number 220-82-0004		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 32 Yrs.		8. Date of Birth (Month, Day, Year) FEB. 28, 1968		9. Birthplace (State or Foreign Country) MARYLAND	
	10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1632 E. 30th STREET				10f. Zip Code 21218				10g. Citizen of What Country? U.S.A.		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CASHIER				16b. Kind of Business/Industry RESTURANTS		
17. Father's Name (First, Middle, Last) REGINALD BAILEY				18. Mother's Name (First, Middle, Maiden Surname) TEENIE WRIGHT						
19a. Informant's Name/Relationship (Type, Print) TEENIE W. MURRAY-MOTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1632 E. 30th STREET, BALTO. MD. 21218						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MOUNT ZION CEMETERY				20c. Location - City or Town, State 11-10-00 LANSDOWNE, MD.		
21. Signature of Funeral Service Licensee Lewis T. Gwynn				22. Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 4517 PARKHEIGHTS AVE. BALTO. MD. 21215-6393						
23a. Part I - Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BACTERIAL ENDOCARDITIS										Approximate Interval Between Onset and Death
Immediata Causa (Final disease or condition resulting in death) a. Due to (or as a consequence of):										
Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):										
c. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
										24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
										24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier [Signature]				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) NOVEMBER 6, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35768

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LAURENCE BURDEN JR.				2. Date of Death Month Day Year November 08, 2000		3. Time of Death 1743 pm	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 220-86-1127	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 36 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) NOV. 10, 1963		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD.	10b. County N/A	10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 3805 W. COLDSRING LANE				10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARPENTER			16b. Kind of Business/Industry CARPENTRY		
	17. Father's Name (First, Middle, Last) LAURENCE L. BURDEN SR.				18. Mother's Name (First, Middle, Maiden Surname) BERNEICE C. HOPEWELL			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) BERNEICE C. HOPEWELL - MOTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3805 W. COLDSRING LANE BALTO. MD. 21215			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MOUNT ZION CEMETERY		Date 11/14/00		20c. Location - City or Town, State LANSDOWNE, MD.	
	21. Signature of Funeral Service Licensee <i>Nancy M. Wallace</i> NANCY M. WALLACE				22. Name and Address of Facility NANCY M. WALLACE FUNERAL SERVICE 3405 WEST FRANKLIN ST. BALTO. MD. 21229			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MULTIPLE GUN SHOT WOUNDS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 11/8/00		28b. Time of Injury 1659 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred SUBJECT WAS SHOT				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET			
	28f. Location (Street and Number or Rural Route Number, City or Town, State) 2638 OSWEGO AVE, BALTIMORE, MD							
State Registrar	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>J. M. D.</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) November 09, 2000	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature <i>Sparks</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35769

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Ronald Burt Beall</u>				2. Date of Death Month <u>November</u> Day <u>9</u> Year <u>2000</u>				3. Time of Death <u>1:30pm</u>						
	4a. Facility Name (If not institution, give street and number) <u>3208 Acton Road</u>				4b. City, Town, or Location of Death <u>Parkville</u>				4c. County of Death <u>Baltimore</u>						
Funeral Director	5. Social Security Number <u>212-34-7790</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>61</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>September 5, 1939</u>		9. Birthplace (State or Foreign Country) <u>West Virginia</u>						
	Usual Residence of Decedent														
10a. State <u>Maryland</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Parkville</u>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number <u>3208 Acton Road</u>				10f. Zip Code <u>21234</u>		10g. Citizen of What Country? <u>U.S.A</u>									
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>White</u>								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Building Maintenance Eng. Mercantile Bank</u>			16b. Kind of Business/Industry								
17. Father's Name (First, Middle, Last) <u>unknown</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Oleta Jane Beall</u>											
19a. Informant's Name/Relationship (Type, Print) <u>Rose Beall - wife</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3208 Acton Road, Parkville, MD 21234</u>											
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Parkwood Cemetery</u>		Date <u>Nov. 13, 2000</u>		20c. Location - City or Town, State <u>Parkville, MD</u>									
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>Evens Funeral Chapel</u> <u>8800 Harford Road, Parkville MD 21234</u>											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Lung Carcinoma</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death <u>18 months</u>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>33624</u>		29d. Date signed (Month, Day, Year) <u>11/10/00</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>JOHN C. JOWNS</u>															
31. Date filed (Month, Day, Year) <u>NOV 13 2000</u>		32. Registrar's Signature <u>[Signature]</u>													

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

80 35770

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES D. BATES SR.						2. Date of Death Month Day Year NOVEMBER 8, 2000			3. Time of Death 3:36pm			
	4a. Facility Name (If not institution, give street and number) 5400 FAIRLAWN AVENUE						4b. City, Town, or Location of Death BALTIMORE			4c. County of Death NA			
Funeral Director	5. Social Security Number 213-03-8740		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 83 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) MARCH 13, 1917		9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent												
10a. State MD		10b. County NA		10c. City, Town or Location BALTIMORE						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 5400 FAIRLAWN AVENUE						10f. Zip Code 21215			10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) NA						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TAILOR			16b. Kind of Business/Industry CLEANERS				
17. Father's Name (First, Middle, Last) WILLIAM BATES						18. Mother's Name (First, Middle, Maiden Surname) SADIE BARNES							
19a. Informant's Name/Relationship (Type, Print) EDMONIA A. BATES						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5400 FAIRLAWN AVENUE BALTIMORE, MD 21215							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK				Date 11/16/00		20c. Location - City or Town, State RANDALLSTOWN, MD			
21. Signature of Funeral Service Licensed						22. Name and Address of Facility WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Adenocarcinoma - lung												Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)													
Due to (or as a consequence of):													
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last													
Due to (or as a consequence of):													
Due to (or as a consequence of):													
Due to (or as a consequence of):													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier CD Kearney MD						29c. License number D0027860			29d. Date signed (Month, Day, Year) November 10th 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTOPHER D. KEARNEY MD 700 WASH. BLVD BART MD 21230													
31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature B. Sparks									

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 23a,b,c, per Phy, 11/13, G789, gap

Certificate of Death

Reg. No.

00 35771

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CLARA V. BECKER

2. Date of Death

OCTOBER 27 2000

3. Time of Death

0046AM

4e. Facility Name (If not institution, give street and number)

St. Joseph Hospital

4b. City, Town, or Location of Death

Baltimore County

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-18-9028

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

2-22-1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

#1 Gorsuch Rd.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 yrs.College (1-4 or 5+)
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Johns Hopkins University

17. Father's Name (First, Middle, Last)

William C. Milbourne

18. Mother's Name (First, Middle, Maiden Surname)

Wilhelmina Schubert

19a. Informant's Name/Relationship (Type, Print)

Eric B. Becker

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

#1 Gorsuch Rd. Timonium, Maryland 21093

20a. Method of Disposition

1 ☐ Burial ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc. 10-28-00

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

E. J. Lasczynski

22. Name and Address of Facility

Lassahn Funeral Home
7401 Belair Rd. Baltimore, Md. 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ~~Asphyxiation~~ Ventricular Fibrillation
Due to (or as a consequence of):

Hour

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ~~ALS~~ Agonal Aspiration
Due to (or as a consequence of):

2 months

c. ALS
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HTN

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

E. J. Lasczynski

29c. License number

D34124

29d. Date signed (Month, Day, Year)

11-3-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. John Milto 1205 York Rd. #20 Lutherville, MD 21093

State
Registrar

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35772

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Edward Brown				2. Date of Death Month November Day 4 Year 2000		3. Time of Death 2:10 PM		
	4a. Facility Name (If not institution, give street and number) 8800 Walther Blvd. Apt. 1405				4b. City, Town, or Location of Death Parkville		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 213-03-1624		6. Sex 1X M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) August 18, 1918		
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Baltimore		10c. City, Town or Location Parkville		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 8800 Walther Blvd. Apt. 1405		10f. Zip Code 21234		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Manager/Traffic Rate Clerk		16b. Kind of Business/Industry Transportation					
17. Father's Name (First, Middle, Last) Jesse T. Brown		18. Mother's Name (First, Middle, Maiden Surname) Margaret Hollerman		19a. Informant's Name/Relationship (Type, Print) Hilda Virginia Brown-wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Walther Blvd., Apt. 1405, Baltimore, MD 21234			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park		20c. Date 11/7/00		20d. Location - City or Town, State Baltimore, MD			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility William G. Dau Leonard J. Ruck, Inc. 5305 Harford Rd.		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Pneumonia b. Parkinson's Disease		Approximate Interval Between Onset and Death 1 week 10 years			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D30182		29d. Date signed (Month, Day, Year) November 6, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Russell MD 8800 Walther Blvd Baltimore MD 21234		31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35773
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Oliver E. Bullen, Jr.				2. Date of Death Month November Day 10 , Year 2000		3. Time of Death 0021	
	4a. Facility Name (If not institution, give street and number) St. Agnes Healthcare				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number 216-07-0413		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) December 30, 1919	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore City		10c. City, Town or Location Baltimore	
Usual Residence of Decedent								
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
10e. Street and Number 4303 Wilkens Avenue								
10f. Zip Code 21229								
10g. Citizen of What Country? United States								
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 4, 42-12, 45			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sheet Metal Worker		
16b. Kind of Business/Industry Sheet Metal			17. Father's Name (First, Middle, Last) Oliver E. Bullen, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Elsie D. Manser		
19a. Informant's Name/Relationship (Type, Print) Edna Bullen-Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4303 Wilkens Avenue, Baltimore, Maryland 21229					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery			20c. Date 11-13-00		
20d. Location - City or Town, State Baltimore, Maryland			21. Signature of Funeral Service Licensee Lisa S. Jefferson			22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)								
a. myocardial infarction								
Due to (or as a consequence of):								
b. atherosclerotic cardiovascular disease								
Due to (or as a consequence of):								
c.								
Due to (or as a consequence of):								
d.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)			28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred			28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier [Signature]			29c. License number D47353			29d. Date signed (Month, Day, Year) November 10, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jon Felix MD, St. Agnes Hospital 900 Caton Avenue Baltimore, Maryland 21229								
31. Date filed (Month, Day, Year) NOV 13 2000			32. Registrar's Signature [Signature]					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35774

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CARL W. BATES, SR.				2. Date of Death Month Day Year NOV 11 2000		3. Time of Death 2215
	4a. Facility Name (If not institution, give street and number) UPPER CHESAPEAKE HOSPITAL-BELAIR				4b. City, Town, or Location of Death BELAIR		4c. County of Death HARFORD
Funeral Director	5. Social Security Number 216-30-1157	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUL 19 1935	9. Birthplace (State or Foreign Country) WASHINGTON DC.
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County HARFORD CO	10c. City, Town or Location EDGEWOOD			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 1585 CHARLESTOWN DRIVE-L COURT				10f. Zip Code 21040		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 54/56		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER		16b. Kind of Business/Industry TRANSPORTATION		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) DABNEY BATES				18. Mother's Name (First, Middle, Maiden Surname) ORA BATES		
	19a. Informant's Name/Relationship (Type, Print) Missouri Bates/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1585 Charlestown Dr., L Court, Edgewood, Md 21040		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST JAMES CEMETERY		Date 11-7-00	20c. Location - City or Town, State HAVRE DE GRACE, MD.	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 321 S PHILADELPHIA BLVD, ABERDEEN MD 21001				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
	Immediate Cause (Final disease or condition resulting in death) a. SUBARACHNOID HEMORRHAGE. Due to (or as a consequence of): b. HEAD TRAUMA. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. IDIOPATHIC COAGULOPATHY						
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) NOV. 11 2000		28b. Time of Injury 215 P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28d. Describe how injury occurred PATIENT FELL OUT OF BED HE WAS CONFUSED		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1585 Charlestown Drive Edgewood Maryland				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier M.D. ATTENDING PHYSICIAN		29c. License number D 21207		29d. Date signed (Month, Day, Year) 11/8/2000		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANZ C. VELLA-CAMILLERI M.D. 5 MIDCREST CT. BALTIMORE, MD. 21286						
	31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35775

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Albert John Barton				2. Date of Death Month Day Year November 8 2000				3. Time of Death 5:30 AM		
	4a. Facility Name (If not institution, give street and number) Knollwood Manor				4b. City, Town, or Location of Death Millersville				4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 193-14-8333		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) OCT 1, 1924		9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Caroline		10c. City, Town or Location Greensboro				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 25840 Brookwood Road				10f. Zip Code 21639		10g. Citizen of What Country? USA					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager				16b. Kind of Business/Industry Restaurant			
17. Father's Name (First, Middle, Last) Clarence S. Barton				18. Mother's Name (First, Middle, Maiden Surname) Emma Blank							
19a. Informant's Name/Relationship (Type, Print) Lois E. Barton/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25840 Brookwood Rd. Greensboro, MD 21639							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		20c. Location - City or Town, State 11-9-00 Baltimore, MD					
21. Signature of Funeral Service Licensee Thomas Gregor				22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Severely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Sepsis b. Urinary Tract Infection c. d.										Approximate Interval Between Onset and Death 2 days 4 days	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Dementia										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier John F. Looe, MD				29c. License number D52728		29d. Date signed (Month, Day, Year) November 8, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John F. Looe, MD 479 Truitts Hill Road #304 Severna Park, MD 21146											
31. Date filed (Month, Day, Year) NOV 08 2000				32. Registrar's Signature G. Sparks							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35776

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DUDLEY BARNETTE				2. Date of Death Month Day Year NOVEMBER 8, 2000		3. Time of Death 6:08 AM	
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death GIEN BURNIE		4c. County of Death AA COUNTY	
Funeral Director	5. Social Security Number 217-14-0231	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 10/18/1921		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Howard	10c. City, Town or Location Ellicott City			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 5125 Bonnie Acres Drive			10f. Zip Code 21043		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist			16b. Kind of Business/Industry Communications		
	17. Father's Name (First, Middle, Last) Dudley W. Barnette				18. Mother's Name (First, Middle, Maiden Surname) Edith Baumann			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Dudley K. Barnette / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 5125 Bonnie Acres Drive Ellicott City, Maryland			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Veteran		Date 11/14/00		20c. Location - City or Town, State Owings Mills Maryland	
	21. Signature of Funeral Service Licensee <i>David J. Weber</i>				22. Name and Address of Facility David J. Weber Funeral Homes, P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death 2 weeks							
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. EMPHYSEMA DEMENTIA				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>OK M.D.</i>		29c. License number D55506	
					29d. Date signed (Month, Day, Year) 11/08/00			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) FER EREN M.D. 3001 SOUTH HANOVER STREET BALTIMORE MD 21225							
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature <i>[Signature]</i>						

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35777

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT BRIGHTSTEIN				2. Date of Death Month NOV. Day 8 Year 2000		3. Time of Death 5:30AM		
	4a. Facility Name (If not institution, give street and number) JEWISH CONVALESCENT & NURSING HOME				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 212-22-9231		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 8, 1917	9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent				10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 3912 FORDS LANE, APT. 103		10f. Zip Code 21215		10g. Citizen of What Country? USA
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry BALTIMORE CITY		
	17. Father's Name (First, Middle, Last) ABRAHAM BRIGHTSTEIN				18. Mother's Name (First, Middle, Maiden Surname) ANNA ALK				
	19a. Informant's Name/Relationship (Type, Print) MRS. IRIS ROSEN (COUSIN)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4600 ALLCOTT WAY, APT. 202 OWINGS MILLS, MD 21117				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HEBREW FRIENDSHIP		Date 11/9/00		20c. Location - City or Town, State BALTIMORE, MD		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebral Hemorrhage Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 6 HOURS
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D15140		29d. Date signed (Month, Day, Year) Nov. 8, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IAN SUNSHINE MD 6210 KINGS HWY, BALT, MD 21215									
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35778

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gim Chiu Choi				2. Date of Death Month November Day 9 Year 2000		3. Time of Death 7:30 AM	
	4a. Facility Name (If not institution, give street and number) 3703 Fieldstone Road				4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-54-2542		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) July 6, 1940	
	9. Birthplace (State or Foreign Country) China		10a. State MD		10b. County Baltimore		10c. City, Town or Location Randallstown	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 3703 Fieldstone Road		10f. Zip Code 21133		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Chinese-American	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chef		16b. Kind of Business/Industry Silver Dragon			
	17. Father's Name (First, Middle, Last) Chun York Choi		18. Mother's Name (First, Middle, Maiden Surname) Tung Liu					
	19a. Informant's Name/Relationship (Type, Print) Diane Choi Yep - Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3726 Fieldstone Road; Randallstown, MD 21133					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Cemetery		20c. Location - City or Town, State 11/14/00 Marriottsville, MD			
	21. Signature of Funeral Service Licensee Joseph Kellner		22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Diabetes Mellitus Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death years years					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Jyoti Parikh		29c. License number D32158		29d. Date signed (Month, Day, Year) 11/10/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jyoti Parikh MD 1113 N. Rolling Road, Catonsville, MD 21228								
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35779

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George E. Crisp				2. Date of Death Month Day Year 11 06 2000		3. Time of Death 12:10pm		
	4a. Facility Name (If not institution, give street and number) Sandtown Nursing Home				4b. City, Town, or Location of Death Baltimore		4c. County of Death		
Funeral Director	5. Social Security Number 721-03-0077		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 05 20 22	9. Birthplace (State or Foreign Country) N.C.	
	Usual Residence of Decedent								
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 3419 Park Heights Ave				10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) na				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager			16b. Kind of Business/Industry Pep Boys		
17. Father's Name (First, Middle, Last) Rascoe Crisp				18. Mother's Name (First, Middle, Maiden Surname) Vallie Crisp					
19a. Informant's Name/Relationship (Type, Print) Rico Paige-Grandson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3419 Park Heights Ave, Baltimore Md 21215					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		20c. Location - City or Town, State 11/10/00 Randallstown, Md			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Pneumonia Due to (or as a consequence of): b. Lung Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Metastatic Lung Cancer Anemia								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number D26748		29d. Date signed (Month, Day, Year) 11/8/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arul Ubeccai MD 4419 Falls Rd Balto. MD 21215									
31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35780

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BERTHA F. CINCOITA				2. Date of Death Month NOV Day 8 Year 2000		3. Time of Death 3:15 AM										
	4a. Facility Name (If not institution, give street and number) GENESIS - LONG GREEN CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death -										
Funeral Director	5. Social Security Number 215-28-2594		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.		8. Date of Birth (Month, Day, Year) JAN 24, 1905										
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD		10b. County -		10c. City, Town or Location BALTIMORE										
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 115 E. MELROSE		10f. Zip Code 21212		10g. Citizen of What Country? U.S.A.										
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry DOMESTIC												
	17. Father's Name (First, Middle, Last) OTTO GRITZNER				18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH LEIMBACH												
	19a. Informant's Name/Relationship (Type, Print) JEANNE E. STITZEL, DAUGH.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14808 POND PINE LN. CLERMONT, FLA 34711												
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) EVANS FUNERAL CHAPEL		Date NOV 11, 2000		20c. Location - City or Town, State FOREST HILL, MD										
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility EVANS FUNERAL CHAPEL 8800 HARTFORD RD. PARKVILLE, MD. 21234												
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. dehydration</td> <td>Approximate Interval Between Onset and Death 5 days</td> </tr> <tr> <td>b. malnutrition</td> <td>1 year</td> </tr> <tr> <td>c. alzheimer's dementia</td> <td>4 years</td> </tr> <tr> <td>d. -</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. dehydration	Approximate Interval Between Onset and Death 5 days	b. malnutrition	1 year	c. alzheimer's dementia	4 years	d. -	
	Immediate Cause (Final disease or condition resulting in death)	a. dehydration	Approximate Interval Between Onset and Death 5 days														
b. malnutrition		1 year															
c. alzheimer's dementia		4 years															
d. -																	
<table border="1"> <tr> <td colspan="4">23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="2">24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> </table>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD atrial fibrillation			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D28987	
29d. Data signed (Month, Day, Year) 11/9/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL SPERLING MD. 5601 Loch Raven Blvd Balto. MD 21239			
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature <i>[Signature]</i>	

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35781

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lillian F. Cash				2. Date of Death Month November Day 11 , Year 2000				3. Time of Death 11:10 a.m.	
	4a. Facility Name (If not institution, give street and number) Heritage Nursing Center				4b. City, Town, or Location of Death Dundalk				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 237-22-5062		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) April 22, 1921		9. Birthplace (State or Foreign Country) North Carolina		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10a. Street and Number 911 1A Garden Drive		10f. Zip Code 21221		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembler		16b. Kind of Business/Industry Electronics		17. Father's Name (First, Middle, Last) Walter Cash		18. Mother's Name (First, Middle, Maiden Surname) Lillian Walters	
	19a. Informant's Name/Relationship (Type, Print) Dianna Adams (niece)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1020 Cherlyn Road, Essex, Maryland 21221		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. Location - City or Town, State Nov. 14, 2000 Durham, North Carolina	
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Bruzdinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. RESPIRATORY FAILURE Due to (or as a consequence of): b. PULMONARY EMBOLISM Due to (or as a consequence of): c. COLON CANCER Due to (or as a consequence of): d. ANEMIA		Approximate Interval Between Onset and Death			
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION			
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, lecture, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Sanjinder K. Taneja M.D.		29c. License number 829188		29d. Date signed (Month, Day, Year) 11/13/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sanjinder K. Taneja 2 Market Place Baltimore MD 21222	
	31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35782

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>ANNA S. CUALINA</i>		2. Date of Death Month <i>11</i> Day <i>08</i> Year <i>2000</i>		3. Time of Death <i>4:00pm</i>
	4a. Facility Name (If not institution, give street and number) <i>7305 German Hill Road</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore</i>
Funeral Director	5. Social Security Number <i>172-16-5612</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>79</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth Month <i>11</i> Day <i>10</i> Year <i>1920</i>		9. Birthplace (State or Foreign Country) <i>PA</i>		
Usual Residence of Decedent					
10a. State <i>MD</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Baltimore</i>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <i>7305 German Hill Road</i>			10f. Zip Code <i>21222</i>		10g. Citizen of What Country? <i>USA</i>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>Caucasian</i>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Caretaker</i>		16b. Kind of Business/Industry <i>Cemetery</i>	
17. Father's Name (First, Middle, Last) <i>Charles Skira</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Unknown</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Mrs. Patricia Rockstroh</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1606 Delvale Avenue, Baltimore, MD 21222</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Holy Rosary</i>		20c. Location - City or Town, State <i>11-13 Baltimore, MD</i>	
21. Signature of Funeral Service Licensee <i>Paul J. Kaczorowski</i>			22. Name and Address of Facility <i>Kaczorowski Funeral Home, P.A. 1201 Dundalk Ave., Baltimore, MD 21222</i>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. <i>Acute Myocardial Infarction</i>					
Due to (or as a consequence of):					
b. <i>CORONARY ARTERY Disease.</i>					
Due to (or as a consequence of):					
c. <i>Hypertension</i>					
Due to (or as a consequence of):					
d.					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>MT</i>		29c. License number <i>D0021859</i>		29d. Date signed (Month, Day, Year) <i>11.10.2000</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>MOHAMMAD TAQI MD. BRENTWOOD Med Centre 6710, HOLABIRD AVE BALT MD 21222</i>					
31. Date filed (Month, Day, Year) <i>NOV 13 2000</i>		32. Registrar's Signature <i>[Signature]</i>			

ORIGINAL

State of New York
County of Albany
In SENATE,
January 10, 1891.

REPORT

OF THE

COMMISSIONER

OF THE LAND OFFICE, IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE, JANUARY 10, 1891.

ALBANY: PUBLISHED BY THE STATE OF NEW YORK, 1891.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35783

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bobbie Gene Clemons

2. Date of Death

Month
Nov.Day
9Year
2000

3. Time of Death

10:08 pm.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

406-44-2794

6. Sex

1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
July 24, 1934

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Kentucky

10b. County

Grayson

10c. City, Town or Location

Leitchfield

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8714 Elizabethtown Rd.

10f. Zip Code

42754

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Die Welder

16b. Kind of Business/Industry

International Harvester

17. Father's Name (First, Middle, Last)

Shelby Thomas Clemons

18. Mother's Name (First, Middle, Maiden Surname)

Flossie Mae Sims

19a. Informant's Name/Relationship (Type, Print)

Gladys I. Clemons - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8714 Elizabethtown Rd. Leitchfield, Ky. 42754

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Hebron Cem. Nov. 13, 2000

Date

20c. Location - City or Town, State

Leitchfield, Ky.

21. Signature of Funeral Service Licensee

D J Smith Eckhardt

22. Name and Address of Facility

Eckhardt Funeral Chapel

11605 Reisterstown Rd. Owings Mills, Md. 21117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. PANCREATIC CANCER

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D J Smith Eckhardt

29c. License number

D43725

29d. Date signed (Month, Day, Year)

11/10/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

D J Smith Eckhardt

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NOVEMBER 9, 2000 10:08 p.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

BOBBIE CLEMONS

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Nov. 1900

Belgium

July 24, 1900

Nov. 1900

Belgium

July 24, 1900

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State of Maryland / Department of Health and Mental Hygiene

00 35784

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Edward DeBarge, Jr.				2. Date of Death Month November Day 10 Year 2000		3. Time of Death 10:40 pm	
	4a. Facility Name (If not institution, give street and number) St. Josephs medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-30-8546		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) April 5, 1933	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Phoenix	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 3110 Stanbury mill Road		10f. Zip Code 21131		10g. Citizen of What Country? U.S.A	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korean		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input checked="" type="checkbox"/>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrical Engineer		16b. Kind of Business/Industry Century Engineering		17. Father's Name (First, Middle, Last) Robert Edward DeBarge	
	18. Mother's Name (First, Middle, Maiden Surname) Thelma King		19a. Informant's Name/Relationship (Type, Print) Alice DeBarge - wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3710 Stanbury Mill Road, Phoenix, MD		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery, Nov. 14, 2000, Parkville, MD		21. Signature of Funeral Service Licensee Stephen Allen		22. Name and Address of Facility 8800 Hartford Road, Parkville, MD 21234		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. myocardial infarct Due to (or as a consequence of): b. coronary artery disease Due to (or as a consequence of): c. hyperlipidemia Due to (or as a consequence of): d.	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) Nov 13 2000		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier M. Kaminski MD		29c. License number D31335		29d. Date signed (Month, Day, Year) 11/13/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3346 Paper Mill Road, Phoenix, MD 21132		31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature B. Sparks		State Registrar	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35785

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Barbara Duncan				2. Date of Death Month Day Year Nov. 9, 2000		3. Time of Death 12:40 PM		
	4a. Facility Name (If not institution, give street and number) Stella Maris				4b. City, Town, or Location of Death Timonium		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 218-40-4884		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 16, 1942		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County Baltimore		10c. City, Town or Location Sparks		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 15729 Home Road		10f. Zip Code 21152		
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Systems Design				16b. Kind of Business/Industry Bell Atlantic				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Henry L. Thoman				18. Mother's Name (First, Middle, Maiden Surname) Ruth Gibson				
	19a. Informant's Name/Relationship (Type, Print) Mrs. Jeanine Dansicker/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15729 Home Road Sparks, Maryland 21152				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		20c. Location - City or Town, State 11/11/00 Towson, Maryland		
	21. Signature of Funeral Service Licensee Michael J. Rudy				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Dementia</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. Signature and title of certifier Mervin Kurland	
	29c. License number 521022							29d. Date signed (Month, Day, Year) 11-10-00	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. KOWALEWSKI 7672 BELAIR RD BALTO MD 21236							31. Date filed (Month, Day, Year) NOV 13 2000	
	32. Registrar's Signature Benjamin Sparks							State Registrar	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #20B PER F.H. 6789 11-13-00 WR.

State of Maryland / Department of Health and Mental Hygiene

00 35786

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Morris Deutch						2. Date of Death Month November Day 05 , Year 2000		3. Time of Death 09:00 pm		
	4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center						4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 218-05-3593		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 97 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 03, 1903		9. Birthplace (State or Foreign Country) Latvia		
	Usual Residence of Decedent										
10a. State MD			10b. County N/A			10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 2505 Wetherburn Road						10f. Zip Code 21209		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumber		16b. Kind of Business/Industry Plumbing			
17. Father's Name (First, Middle, Last) Charles Deutch						18. Mother's Name (First, Middle, Maiden Surname) Dusha (unknown)					
19a. Informant's Name/Relationship (Type, Print) Harriet J. Cohen/Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2505 Wetherburn Road - Baltimore, MD 21209					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of Cemetery or other place) (ANSHE EMUNAH) AITZ CHAIM			20c. Date 11/8/00		20d. Location - City or Town, State BALTIMORE, MD			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SMALL BOWEL OBSTRUCTION Due to (or as a consequence of): b. ASPIRATION PNEUMONIA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 5 DAYS 5 DAYS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 						29c. License number 053430		29d. Date signed (Month, Day, Year) NOVEMBER 6 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRED CHAN 6701 NORTH CHARLES STREET BALTIMORE MARYLAND 21204											
31. Date filed (Month, Day, Year) NOV 13 2000			32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35787

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PHILIP H. DAVIS				2. Date of Death Month Day Year NOVEMBER 3, 2000				3. Time of Death 3:38 PM	
	4a. Facility Name (If not institution, give street and number) 3939 Roland Avenue #417				4b. City, Town, or Location of Death Baltimore				4c. County of Death	
Funeral Director	5. Social Security Number 059-03-0809		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) June 25, 1914		9. Birthplace (State or Foreign Country) NY	
	Usual Residence of Decedent				10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 3939 Roland Avenue #417				10f. Zip Code 21211	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4or 5+) unk	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk				16b. Kind of Business/Industry unk				17. Father's Name (First, Middle, Last) Frederick J. Davis	
	18. Mother's Name (First, Middle, Maiden Surname) Frances A. Hyland				19a. Informant's Name/Relationship (Type, Print) unk				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)				20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201				23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)				28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Richard M. Hirata, MD		
29c. License number D26585				29d. Date signed (Month, Day, Year) 11/7/2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD M. HIRATA, Ste 200W, 6569 N. Charles St, Towson, Md 21204		
31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature B. Sparks				State Registrar		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35788

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHOY KAY DEA			2. Date of Death Month NOV Day 3 Year 2000		3. Time of Death 0550	
	4a. Facility Name (If not Institution, give street and number) JOHN L. DEATON MEDICAL CENTER			4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-62-7375		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) DEC. 22, 1922
	9. Birthplace (State or Foreign Country) CHINA		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE
Usual Residence of Decedent							
10e. Street and Number 5413 CRISMER AVENUE				10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: ASIAN	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME	
17. Father's Name (First, Middle, Last) (UNKNOWN)				18. Mother's Name (First, Middle, Maiden Surname) (UNKNOWN)			
19a. Informant's Name/Relationship (Type, Print) JUNE DEA / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11511 NEVIS DRIVE - BELTSVILLE, MD 20705			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LORRAINE MEMORIAL PARK		20c. Location - City or Town, State 11/9/00 WOODLAWN, MD		20d. Date	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HYDROCEPHALUS Due to (or as a consequence of): b. MEINGIOMA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Approximate Interval Between Onset and Death 6 months							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PULMONARY TUBERCULOSIS HYPERTENSION						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number 047945		29d. Date signed (Month, Day, Year) NOV 03, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARRIS ACEEM 9101 FRANKLIN SQUARE DRIVE BALTIMORE MD 21237							
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 					

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Dea, Choy-Kay
Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

00 35789

ORIGINAL

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Physician
/Medical
Examiner**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#23a perPHYG789 11/13/2000 EW

Certificate of Death

Reg. No. 00 35790

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELLEN EITEL						2. Date of Death Month OCTOBER Day 29 Year 2000		3. Time of Death 9:30PM		
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND HOSPITAL						4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE CITY		
Funeral Director	5. Social Security Number 216-68-3120		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) DEC. 9, 1919		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10e. State MD		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 1 W. Conway Street, Apt. 1101					10f. Zip Code 21201		10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home				
17. Father's Name (First, Middle, Last) Joseph Smith						18. Mother's Name (First, Middle, Maiden Surname) Christina Fitchenbeiner					
19a. Informant's Name/Relationship (Type, Print) Gayeann Day - daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2921 Baltimore Avenue, Baltimore, Md. 21227						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Pk.			Date 11/02/00		20c. Location - City or Town, State Elkridge, Md.			
21. Signature of Funeral Service Licensee Mag K. Marshall					22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS BOWEL PERFORATION								Approximate Interval Between Onset and Death 24 HOURS		
	Due to (or as a consequence of): BOWEL PERFORATION										
	Due to (or as a consequence of):										
	Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SQUAMOUS CELL CARCINOMA OF LUNGS NEUTROPENIA.										23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
										24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Campbell Resident Physician					29c. License number P12375		29d. Date signed (Month, Day, Year) OCTOBER 29, 2000.				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRACE CAMPBELL 22 S. GREENE ST. N3ED9 BALTIMORE, MD 21201											
State Registrar		31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

00 35791

DMMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35792

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) YERDON N. FRANCIS				2. Date of Death Month Day Year November 8 2000				3. Time of Death 17:41	
	4a. Facility Name (If not institution, give street and number) UNION MEM Hosp				4b. City, Town, or Location of Death BALTO				4c. County of Death N.A	
Funeral Director	5. Social Security Number 213 30 5317		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 3-27-34		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County N.A.		10c. City, Town or Location BALTO				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1215 N. Eden ST.				10f. Zip Code 21213		10g. Citizen of What Country? U.S.A			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 10/2/56		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER				16b. Kind of Business/Industry Post Office			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) MASTON FRANCIS				18. Mother's Name (First, Middle, Maiden Surname) LOUISE EUBANKS					
	19a. Informant's Name/Relationship (Type, Print) LINDA KELLEY				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1215 N. Eden St. BALTO, MD 21213					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Barren Forest Cem		Date 11/15/00		20c. Location - City or Town, State OWINGS MILLS, MD.			
	21. Signature of Funeral Service Licensee Joseph B. Locks Jr				22. Name and Address of Facility Joseph B. Locks Jr 3/H. 1304 N. Central Ave					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Immediate Cause (Final disease or condition resulting in death)		a. Hypercarbia Dued to (or as a consequence of):						Approximate Interval Between Onset and Death Thirty five minutes	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Aspiration pneumonia Dued to (or as a consequence of):						2 days	
			c. and hypoxic brain injury Dued to (or as a consequence of):						2 days	
d.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Epilepsy										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier E. S. Feen, MD				29c. License number AT2438946-A2				29d. Date signed (Month, Day, Year) November 8, 2000		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) E.S. Feen, UNION MEMORIAL, DEPT. OF MEDICINE, 201 E UNIVERSITY PKWY, BALTO, MD 21218										
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature Benjamin P. Sparks								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35793

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES HENRY FOUNTAIN				2. Date of Death Month Day Year November 7, 2000		3. Time of Death 8:00 pm	
	4a. Facility Name (If not institution, give street and number) FOREST HAVEN NURSING HOME				4b. City, Town, or Location of Death CATONSVILLE		4c. County of Death BALTIMORE CO	
Funeral Director	5. Social Security Number 213-12-4405		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) JAN 28 1919	
	9. Birthplace (State or Foreign Country) WASHINGTON, D.C.		10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location CATONSVILLE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 315 INGLESIDE AVENUE		10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 42/45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CAB DRIVER		16b. Kind of Business/Industry TRANSPORTATION			
	17. Father's Name (First, Middle, Last) FRANK FOUNTAIN				18. Mother's Name (First, Middle, Maiden Surname) GERTRUDE FOUNTAIN			
	19a. Informant's Name/Relationship (Type, Print) Robert Fountain/Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8950 F Town & Country Blvd, Ellicott City, Md 21043			
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CROWNSVILLE VETERANS		20c. Location - City or Town, State 11-13-00 CROWNSVILLE, MD			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W. NORTH AVENUE					
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Aspiration PNEUMONIA							
	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
	24a. Was an autopsy performed? 1 Yes 2 No							
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No								
Physician /Medical Examiner	25. Was case referred to medical examiner? 1 Yes 2 No							
	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 		29c. License number D28595		29d. Date signed (Month, Day, Year) 11/9/00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TASNEEM AKHANNI, 7220 PARK HEIGHTS AVE BALTO MD							
	31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

THE
OFFICE OF THE
ATTORNEY GENERAL
STATE OF NEW YORK
ALBANY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35794

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rose Marie Fulco				2. Date of Death Month November Day 7 Year 2000		3. Time of Death 5:40 p.m.	
	4a. Facility Name (If not institution, give street and number) 1095 Oakland Road				4b. City, Town, or Location of Death Freeland		4c. County of Death Baltimore Co.	
Funeral Director	5. Social Security Number 219-28-5730		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 24, 1916	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Freeland			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 1095 Oakland Road				10f. Zip Code 21053		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 yrs.				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Frederick Walzog				18. Mother's Name (First, Middle, Maiden Surname) Rose M. Siefert				
19a. Informant's Name/Relationship (Type, Print) Mr. Frederick L. Fulco, Sr. /son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1095 Oaklawn Road Freeland, Maryland 21053				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. Location - City or Town, State 11/10/00 Baltimore, Maryland		
21. Signature of Funeral Service Licensee Michael E. Canapp 				22. Name and Address of Facility LEONARD J. RUCK, INC. 5305 Harford Road Baltimore, MD 21214				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial infarction Due to (or as a consequence of): b. Emphysema Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number 050760		29d. Date signed (Month, Day, Year) 11/7/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Weng, M.D. 515 Fairmount Avenue Towson, Maryland 21286								
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 33a or 33a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner


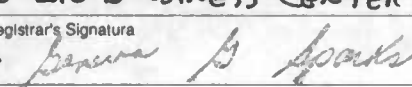
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35795

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) STANLEY J. FAJKOWSKI, SR.				2. Date of Death Month OCT. Day 30, Year 2000		3. Time of Death 2:45AM	
	4a. Facility Name (If not institution, give street and number) 224 S. BOULDIN STREET				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-05-4000	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11/7/11	9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent							
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 224 S. BOULDIN STREET				10f. Zip Code 21224		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PICKLE MANUFACTURER		16b. Kind of Business/Industry BORSHAY'S		
17. Father's Name (First, Middle, Last) JOSEPH FAJKOWSKI				18. Mother's Name (First, Middle, Maiden Surname) TEOFILIA MURAWSKI				
19a. Informant's Name/Relationship (Type, Print) CONSTANCE KRYSIAK				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5603 CHATHAN RD. BALTIMORE, MD. 21225				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HOLY ROSARY CEME.		Date 11/03/00		20c. Location - City or Town, State DUNDALK, MD.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility KACZOROWSKI FUNERAL HOME P.A. 2525 FLEET STREET BALTIMORE, MD. 21224				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. CARDIOMYOPATHY Due to (or as a consequence of): b. HYPERTENSION Due to (or as a consequence of): c. ARRHYTHMIAS Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 5yr 20yr 1yr								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier J. Allen Reilly M.D.				29c. License number D 54749		29d. Date signed (Month, Day, Year) 11 03 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Allen Reilly MD 216 BUSINESS CENTER DR. REISTERTOWN, MD 21134								
State Registrar		31. Data filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #F PER F.H. G789 11-13-00 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35796

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) RUTH E FRIBUSH		2. Date of Death Month NOV. Day 8 Year 2000		3. Time of Death 5:55AM
4a. Facility Name (If not institution, give street and number) MILFORD MANOR NURSING HOME		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE
5. Social Security Number 220-12-2822	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	8. Date of Birth (Month, Day, Year) DEC. 29, 1925	9. Birthplace (State or Foreign Country) MARYLAND
Usual Residence of Decedent				
10a. State MD	10b. County BALTIMORE	10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 4721 MARYKNOLL RD.		10f. Zip Code 21208		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) HOMEMAKER		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWN HOME		16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) FREDERICK FOGLER		18. Mother's Name (First, Middle, Maiden Surname) ROSALYN TWELE		
19a. Informant's Name/Relationship (Type, Print) MERVIN FRIBUSH (HUS.)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4721 MARYKNOLL RD. BALTIMORE, MD 21208		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BNAI ISRAEL		20c. Location - City or Town, State 11/10/00 BALTIMORE, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208		
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death 10 days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Menigioma				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury 11/10/00
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier 		29c. License number D27034		29d. Date signed (Month, Day, Year) November 8 2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L.H. Capeland MD 1838 Greentree Road Pikesville MD 21208				
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 		

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #14 PER F.H. G789 11-13-00 WR.

State of Maryland / Department of Health and Mental Hygiene

00 35797

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Monico Regalado Fortuno				2. Date of Death Month Day Year November 9 2000		3. Time of Death 2:45 PM	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-08-1716	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	8. Date of Birth (Month, Day, Year) May 4, 1945	9. Birthplace (State or Foreign Country) Philippines			
	Usual Residence of Decedent							
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 3116 Remington Avenue				10f. Zip Code 21211		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. ASIAN Specify: Filipino		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Police Officer		16b. Kind of Business/Industry Maryland State Government		
17. Father's Name (First, Middle, Last) Ambrosio Beltran Fortuno				18. Mother's Name (First, Middle, Maiden Surname) Rosario Baylon Regalado				
19a. Informant's Name/Relationship (Type, Print) Leody Valiente Fortuno (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3116 Remington Avenue Baltimore, Maryland 21211				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Nabua Cemetery		Date 11/22/00		20c. Location - City or Town, State Nabua, Philippines		
21. Signature of Funeral Service Licensed Martin D. Lawson				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>cholangiocarcinoma</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier [Signature]				29c. License number 00091526		29d. Date signed (Month, Day, Year) November 9, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen Garden MD 6601 North Charles St Baltimore MD 21204								
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature [Signature]						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35798

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>CHARLES F. GOODEN</i>				2. Date of Death Month <i>Nov.</i> Day <i>10</i> Year <i>2000</i>		3. Time of Death <i>1:30 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>2124 Northland Road</i>				4b. City, Town, or Location of Death <i>Woodlawn</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>218-01-2999</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>95 Yrs.</i>		8. Date of Birth (Month, Day, Year) <i>June 12, 1905</i>	
	9. Birthplace (State or Foreign Country) <i>Maryland</i>		10a. State <i>MD</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Woodlawn</i>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <i>2124 Northland Road</i>				10f. Zip Code <i>21207</i>		10g. Citizen of What Country? <i>USA</i>	
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th Grade</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Airport Manager</i>		16b. Kind of Business/Industry <i>Aviation</i>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>Benjamin Franklin Gooden</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Elizabeth Comstock Freeman</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Hollis Larrimore - Niece</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>105 Waldron Ave.; Pikesville, MD 21208</i>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Lorraine Park</i>		Date <i>11/13/00</i>		20c. Location - City or Town, State <i>Woodlawn, MD</i>	
	21. Signature of Funeral Service Licensee <i>Joseph Kellner</i> <i>MOOJ23</i>		22. Name and Address of Facility <i>Loring Byers Funeral Directors Inc.</i> <i>8728 Liberty Road; Randallstown, MD 21133</i>					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>CARCINOMA COLON</i> <i>RECTAL BLEED</i>							Approximate Interval Between Onset and Death
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							27d. Describe how injury occurred
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>SWADESHK BHATANI</i>				29c. License number <i>D-15300</i>		29d. Date signed (Month, Day, Year) <i>11-10-2000</i>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>SWADESHK BHATANI 6609 REISTERSTOWN ROAD SUITE 109 BALTIMORE MARYLAND 21215</i>							
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) <i>NOV 13 2000</i>				32. Registrar's Signature <i>[Signature]</i>			

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State of Maryland / Department of Health and Mental Hygiene

00 35799

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carl Lee Geisler				2. Date of Death Month Day Year November 7 2000		3. Time of Death 3:40 A.M.	
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER				4b. City, Town, or Location of Death ROSEDALE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 412-24-0832		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) June 12, 1921	
	9. Birthplace (State or Foreign Country) Tennessee		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Middle River	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 711 A Wampler Road		10f. Zip Code 21220	
	10g. Citizen of What Country? United States				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steam Fitter				16b. Kind of Business/Industry Steel Industry		17. Father's Name (First, Middle, Last) William Preston Geisler	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Ellen Gertrude Ahuaride				19a. Informant's Name/Relationship (Type, Print) Mrs. Virginia D. Geisler (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 A Wampler Road Middle River, MD 21220	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem.		20c. Location - City or Town, State 11/10/2000 Rosedale, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>CARDIO VASCULAR ACCIDENT</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 4 DAYS			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 			
	29c. License number 028717				29d. Date signed (Month, Day, Year) November 8, 2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN SELINGER, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237				31. Date filed (Month, Day, Year) NOV 13 2000			
	32. Registrar's Signature 				State Registrar			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene 00 35800

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN CLARKE GRIFFIN				2. Date of Death Month Day Year November 9, 2000		3. Time of Death 11:50PM	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-24-8623	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 14, 1929		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 12 Hampshire Woods Ct				10f. Zip Code 21204		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lawyer		16b. Kind of Business/Industry Private Practice		
17. Father's Name (First, Middle, Last) Hiram Cleaver Griffin				18. Mother's Name (First, Middle, Maiden Surname) Emma Dold Borum				
19a. Informant's Name/Relationship (Type, Print) Virginia Hardesty Griffin Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Hampshire Woods Court Towson, Maryland 21204				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery		20c. Location - City or Town, State 11/10/00 Baltimore, Maryland		
21. Signature of Funeral Service Licensee <i>Stephen Kenak</i>				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lower Gastrointestinal Bleed Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Abheimer-type Dementia								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Hospice								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Stephen Kenak MD</i>				29c. License number D33400		29d. Date signed (Month, Day, Year) 11/10/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tredell W. Idehart MD 500 W University Hwy Balto MD 21210								
31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature <i>Benjamin S. Sparks</i>				

ORIGINAL

ADH

ELIJAH HOUSE

00-6354-510

amend item 23a,27 per me G789 11/30/00 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35801

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elijah L. House				2. Date of Death Month Day Year NOVEMBER 8, 2000		3. Time of Death 2250 PM	
	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death NA	
Funeral Director	5. Social Security Number 218-44-5993		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 53 Yrs.		8. Date of Birth (Month, Day, Year) 11-06-47	
	10e. State MD		10b. County NA		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 514 Sheridan Avenue				10f. Zip Code 21212		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade		College (1-4 or 5+) NA		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance		16b. Kind of Business/Industry Baltimore City Waxter Center	
	17. Father's Name (First, Middle, Last) Leroy House				18. Mother's Name (First, Middle, Maiden Surname) Rosalie Battle			
	19a. Informant's Name/Relationship (Type, Print) Lillie V. House				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212 514 Sheridan Avenue Baltimore, Maryland			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens		20c. Location - City or Town, State 11-14-2000 Dundalk, MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEIZURE DISORDER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number OCME		29d. Date signed (Month, Day, Year) NOVEMBER 9, 2000	
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. L. LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201							
	31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35802

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy C. Hoffman

2. Date of Death

November 5, 2000

3. Time of Death

6:15 pm

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare-Hamilton Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-66-5344

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 28, 1911

9. Birthplace (State or Foreign Country)

N. C.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5118 Harford Rd.

10f. Zip Code

21214

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

1-4 or 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Clem Jordan

18. Mother's Name (First, Middle, Maiden Surname)

Minnie McCall

19a. Informant's Name/Relationship (Type, Print)

Catherine H. Cohn-niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 Goucher Woods Ct., Baltimore, MD 21286

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer Cemetery

Date

11/10/00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

▶

William G. Dau

22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.

5305 Harford Rd., Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure
Due to (or as a consequence of):b. Chronic obstructive Pulmonary Disease
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Osteoporosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶

C. Vergara - Soares MD

29c. License number

D16619

29d. Date signed (Month, Day, Year)

November 5, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. VERGARA - SOARES

6040 HARFORD RD. BALTIMORE, MD 21214

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

▶

B. Soares

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 33a or 33b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35803

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Violet Elizabeth Hesson				2. Date of Death Month Day Year November 5, 2000				3. Time of Death 1:50 pm	
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare-Hamilton Center				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-03-1391		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) June 3, 1913		9. Birthplace (State or Foreign Country) Baltimore, MD	
	Usual Residence of Decedent									
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1801 Crestview Road				10f. Zip Code 21239		10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collegia (1-4or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry own home			
17. Father's Name (First, Middle, Last) Henry DeBelius					18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Belle Freeman					
19a. Informant's Name/Relationship (Type, Print) Charles E. Hesson-husband					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1801 Crestview Rd., Baltimore, MD 21239					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corporation		20c. Date 11/7/00		20d. Location - City or Town, State Towson, MD			
21. Signature of Funeral Service Licensed  William G. Dau			22. Name and Address of Facility Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <u>Arrhythmia</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										Approximate Interval Between Onset and Death <u>6 months</u>
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number D45475		29d. Date signed (Month, Day, Year) 11-6-00			
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Dr. Mohammed Rahmana 8100 Harford Rd Balto, md 21234										
31. Date filed (Month, Day, Year) NOV 13 2000			32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35804

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bertha Heckcrote				2. Date of Death Month Day Year Nov. 7, 2000				3. Time of Death 4:00AM	
	4a. Facility Name (If not institution, give street and number) 4206 Anntana Avenue				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 109-16-8155		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Jan. 3, 1923		9. Birthplace (State or Foreign Country) Pennsylvania		10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore	
Usual Residence of Decedent										
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
10e. Street and Number 4206 Anntana Avenue										
10f. Zip Code 21206										
10g. Citizen of What Country? U.S.A.										
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced										
12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:										
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:										
14. Race - American Indian, Black, White, etc. Specify: White										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+) 9										
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Factory Worker										
16b. Kind of Business/Industry Factory										
17. Father's Name (First, Middle, Last) Charles Koroly										
18. Mother's Name (First, Middle, Maiden Surname) Bertha Giles										
19a. Informant's Name/Relationship (Type, Print) Edgar Heckcrote- Spouse										
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4206 Anntana Avenue Baltimore, Maryland 21206										
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)										
20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet. Cemetery										
20c. Location - City or Town, State Baltimore, Maryland										
21. Signature of Funeral Service Licensee Heather Cain Heather Cain										
22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. head and neck Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 1 year										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Parker Hadden										
29c. License number P 12408										
29d. Date signed (Month, Day, Year) 11/10/00										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert HADDAD 22 S Greene street Baltimore, MD, 21201										
31. Date filed (Month, Day, Year) NOV 13 2000										
32. Registrar's Signature B. Sparks										

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Dwight A. Harrell

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35805

amend item 23a,27,28a,b,c,d,e,f per me G789 11/14/00 yf

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dwight A. Harrell				2. Date of Death Month Day Year November 01 2000				3. Time of Death 10:58 P.M.	
	4a. Facility Name (If not institution, give street and number) Maryland General Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 215-58-2594		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) July 31, 1950		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent				10a. State MD				10b. County N/A	
10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
10e. Street and Number 2206 Bryant Avenue				10f. Zip Code 21217				10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Collega (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Self Employed		
17. Father's Name (First, Middle, Last) Donald S. Harrell Sr.				18. Mother's Name (First, Middle, Maiden Surname) Medorah E. Reed						
19a. Informant's Name/Relationship (Type, Print) Medorah E. Harrell				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3425 Milford Mill RD., Balto., Md 21244						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cem.				20c. Location - City or Town, State 11/9 Baltimore, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Nutter Funeral Home Inc.				2501 Gwynns Falls Pkwy., Balto., Md 21216		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. ACUTE NARCOTIC INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) found: 11/1/00		28b. Time of Injury unknown M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred unknown						
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found at home				28f. Location (Street and Number or Rural Route Number, City or Town, State) 2206 Bryant Avenue Baltimore, Maryland		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number O.C.M.E.		
				29d. Date signed (Month, Day, Year) November 2, 2000						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis J Chute MD				111 Penn Street, Baltimore, Maryland 21201						
31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature 						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35806

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary E. Holland				2. Date of Death Month November Day 6 Year 2000		3. Time of Death 2055		
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 199-26-2014		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) May 24, 1920		
	10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) 4				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse				16b. Kind of Business/Industry St. Agnes Hospital	
17. Father's Name (First, Middle, Last) George R. Coleman				18. Mother's Name (First, Middle, Maiden Surname) Anna Jefferson					
19a. Informant's Name/Relationship (Type, Print) Angela C. Samuels-niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 669, Bowling Green, VA 22427					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Arbutus Memorial Park				20b. Place of Disposition (Name of cemetery, crematory or other place) 11/11 Baltimore, MD				20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee J. Robert E. Nutter				22. Name and Address of Facility Nutter Funeral Home Inc. 2501 Gwynns Falls Pkwy., Balto., MD 21216					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ovarian Metastatic Cancer Due to (or as a consequence of): b. Fungal Sepsis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death Six Years Seven Days					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
				24a. Was an autopsy performed? 1 Yes 2 No				24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No	
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier T. Rau M.D.				29c. License number P12601	
				29d. Date signed (Month, Day, Year) November 6, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Todd Rau 9000 Patton Avenue Baltimore, MD 21229									
31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature [Signature]					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35807

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

TALLIE HYATT

2. Date of Death

November 4, 2000

3. Time of Death

10:45 p

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

213-32-8217

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97 Yrs

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar 28, 1903

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2220 Madison Ave 2nd fl

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private family

17. Father's Name (First, Middle, Last)

JOHN RUCKER

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE

19a. Informant's Name/Relationship (Type, Print)

Georgia Winder Iniece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2504 Brookfield Ave Baltimore, Md 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

11-11-2000

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Gray Harris

22. Name and Address of Facility

CHATHAM - HARRIS Funeral Home
5240 REISTERSTOWN ROAD
BALTIMORE, MD 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive HEART Failure

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Eric Marcolus, M.D.

29c. License number

P13526

29d. Date signed (Month, Day, Year)

11/4/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERIC MARCOLUS, M.D. 91 Maryland General Hospital

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

Geneva B. Sparks

State Registrar

Hyatt, Tallie
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35808

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Ruth L. Jones				2. Date of Death Month Nov. Day 08 Year 2000		3. Time of Death 3:30pm	
4a. Facility Name (If not institution, give street and number) 1716 East 31st. Street				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA	
5. Social Security Number 212-22-3746		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 04-01-17	
9. Birthplace (State or Foreign Country) SC							
Usual Residence of Decedent							
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1716 E. 31st. Street				10f. Zip Code 21218		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade College (1-4or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic		16b. Kind of Business/Industry someone else home	
17. Father's Name (First, Middle, Last) Charlie Ligon				18. Mother's Name (First, Middle, Maiden Surname) Lola Duncan			
19a. Informant's Name/Relationship (Type, Print) Princetta Coles				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1716 E. 31st. Street Baltimore, MD 21218			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hills Cemetery		Date 11-03-2000		20c. Location - City or Town, State MD. Middle River,	
21. Signature of Funeral Service Licensee <i>Tracy Chapman Gentry</i>				22. Name and Address of Facility March FH 1101 E. NORTH AVE.			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIAC ARREST Due to (or as a consequence of): b. ATHEROSCLEROSIS Due to (or as a consequence of): c. CORONARY ARTERY DISEASE Due to (or as a consequence of): d.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SICK SINUS RENAL INSUFFICIENCY							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Dr. [Signature]</i>				29c. License number D 37280		29d. Date signed (Month, Day, Year) 11/9/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GERALD INSEL GOOD SAMARITAN HOSPITAL - 5601 Loch Raven Blvd.							
31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature <i>[Signature]</i>			

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35809

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ERNEST JOHNSON

2. Date of Death

11 11 00

3. Time of Death

1040pm

4a. Facility Name (If not institution, give street and number)

UNIV. OF MARYLAND MEDICAL SYSTEM

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

Funeral
Director

5. Social Security Number

217227188

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

1/16/25

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

210 Altamont Avenue

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: USA

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

Unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Usher

16b. Kind of Business/Industry

Movie Theater

17. Father's Name (First, Middle, Last)

Robin R. Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Mary Sutherland

19a. Informant's Name/Relationship (Type, Print)

Ruth Obitz (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6219 Commons Road, Baltimore, Md. 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

11/15

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

Lynn B. Henss

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road, Baltimore, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. BRADYCARDIA/ASYSTOLE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shirley Koryand

29c. License number

13127

29d. Date signed (Month, Day, Year)

11/11/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UNIV. OF MARYLAND MEDICAL SYSTEM BALTO., MARYLAND

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

Benita B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35810

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sally Ruth Johnson				2. Date of Death Month Day Year November 8, 2000		3. Time of Death 12:50 p.m.	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 218-28-8289	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 06 16 32		9. Birthplace (State or Foreign Country) S.C.
	Usual Residence of Decedent							
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1905 Dukeland Street				10f. Zip Code 21216		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade College (1-4 or 5+) na				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Care Nursing		16b. Kind of Business/Industry Staffing Health Care Service		
17. Father's Name (First, Middle, Last) Horace Johnson				18. Mother's Name (First, Middle, Maiden Surname) Sadie Hughes				
19a. Informant's Name/Relationship (Type, Print) Ethel Blakely-Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1905 Dukeland Street, Baltimore Md 21216				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MD National Park Cem.		20c. Location - City or Town, State 11/14/00 Laurel, Md		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Intracerebral Hemorrhage Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 			29c. License number RBS-000		29d. Date signed (Month, Day, Year) 11/10/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lissa K. Magloire, MD, 2401 West Belvedere Ave., Baltimore, MD 21215								
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35811

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eliza A Jenkins				2. Date of Death Month Day Year November 11, 2000				3. Time of Death 10:10 AM	
	4a. Facility Name (If not institution, give street and number) University of Maryland Medical System				4b. City, Town, or Location of Death Baltimore City				4c. County of Death N/A	
Funeral Director	5. Social Security Number 220-30-2941		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth Month Day Year April 26, 1932		9. Birthplace (State or Foreign Country) S. Carolina		10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 2121 Windsor Garden Lane		10f. Zip Code 21207		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 YRS.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Licensed Practical Nurse		16b. Kind of Business/Industry Nursing Home					
	17. Father's Name (First, Middle, Last) John W. Woods				18. Mother's Name (First, Middle, Maiden Surname) Eliza Smith					
	19a. Informant's Name/Relationship (Type, Print) Avon Prevooe - daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3030 Kenyon Ave. Balto, MD. 21213					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Mem. Park		20c. Location - City or Town, State 11-15-00 Randallstown, MD.					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gary P. March Funeral Home P.A. 270 Fredrickson Pass Balto, MD. 21229					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypoxemia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death 12 hours	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure Acute renal failure								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number P14702				29d. Date signed (Month, Day, Year) November 11, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pajman Alexander Danai, 22 South Greene Street, Baltimore MD 21204										
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 35812
 2. Date of Death Month 10 Day 26 Year 2000
 3. Time of Death 4:25 a.m.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)
 SARAH JANE JOHNSON

4e. Facility Name (If not institution, give street and number)
 300 MORRIS HILL AVENUE

4b. City, Town, or Location of Death
 GLEN BURNIE

4c. County of Death
 ANNE ARUNDEL CO.

Funeral Director

5. Social Security Number
 225-16-9975

6. Sex
 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)
 83 Yrs.

If Under 1 Year
 Months Days

If Under 24 Hrs.
 Hours Min.

8. Date of Birth
 12/31/1916

9. Birthplace (State or Foreign Country)
 VIRGINIA

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

MARYLAND ANNE ARUNDEL CO.

GLEN BURNIE

1 ☐ Yes 2 ☒ No

10e. Street and Number

300 MORRIS HILL AVENUE

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
 If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
 9th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

SELF-EMPLOYED

17. Father's Name (First, Middle, Last)

ROY C. WYATT

18. Mother's Name (First, Middle, Maiden Surname)

CELIA BOONE

19a. Informant's Name/Relationship (Type, Print)

CELIA L. NUTTER/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

300 MORRIS HILL AVENUE, GLEN BURNIE, MARYLAND 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MEADOWRIDGE MEMORIAL PARK

Date

11/1/00

20c. Location - City or Town, State

ELKRIDGE, MARYLAND

21. Signature of Funeral Service Licensee

Charles H. Powell

22. Name and Address of Facility

William C. Brown Community Funeral Home
 1206 W. North Avenue, Baltimore, Maryland 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Myocardial Infarction*
 Due to (or as a consequence of):

1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Coronary artery Disease*
 Due to (or as a consequence of):

5 yr

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus
Multiple Myeloma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Malik R. El-Hamary

29c. License number

D25044

29d. Date signed (Month, Day, Year)

11/8/2000

30. Name and address of person who completed cause of death (Item 23a). (Type, Print)

Malik R. El-Hamary MD 2717 Hammond Road BALTO MD 21223

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

James B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten notes in cursive script, mostly illegible due to fading. Some words like "the" and "and" are visible.

Handwritten notes in cursive script, mostly illegible due to fading. Some words like "the" and "and" are visible.

Handwritten notes in cursive script, mostly illegible due to fading. Some words like "the" and "and" are visible.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35813

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Thomas R Johnson Sr.</i>		2. Date of Death Month Day Year November 7, 2000		3. Time of Death 1:30PM
	4a. Facility Name (If not institution, give street and number) 5904 Prince George Street		4b. City, Town, or Location of Death Catonsville Manor		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 220-12-8856	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) July 8, 1923		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville Manor	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 5904 Prince George Street			10f. Zip Code 21207		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Transportation	
17. Father's Name (First, Middle, Last) Fenton Johnson		18. Mother's Name (First, Middle, Maiden Surname) Olie Hungerford			
19a. Informant's Name/Relationship (Type, Print) Josephine Johnson / Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5904 Prince George Street Baltimore, Maryland 21207			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakeview Memorial		20c. Location - City or Town, State 11/10/00 Sykesville, Maryland	
21. Signature of Funeral Service Licensee <i>David J. Weber</i>		22. Name and Address of Facility David J. Weber Funeral Homes, P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
a. <i>metastatic colon cancer</i>		1 yr			
b. <i>stroke</i>		1 yr			
c. <i></i>					
d. <i></i>					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>David J. Weber, Physician</i>		29c. License number D 29769		29d. Date signed (Month, Day, Year) 11/9/00	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Marcelino D. Alvarado 516 N. Kellway Rd Baltimore</i>					
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature <i>David J. Weber</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM# 23B PER PHY G789 11-30-00 WR.

Certificate of Death

Reg. No.

00 35814

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CAROL P. KURZMANN				2. Date of Death Month November Day 10 Year 2000		3. Time of Death 4:31 P.M.	
	4a. Facility Name (If not institution, give street and number) GILCHRIST CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 143 34 3763	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT 9, 1943		9. Birthplace (State or Foreign Country) NEW JERSEY
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County HARFORD		10c. City, Town or Location FOREST HILL			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 3351 KREITLER ROAD				10f. Zip Code 21050		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12YRS. College (14 or 5+) 2YRS.				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry AT HOME	
17. Father's Name (First, Middle, Last) JOHN W. PROUDFIT				18. Mother's Name (First, Middle, Maiden Surname) DOROTHY BJERRING				
19a. Informant's Name/Relationship (Type, Print) MALIN KURZMANN				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3351 KREITLER ROAD FOREST HILL MARYLAND 21050				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) HIGHVIEW MEMORIAL GAR.		20c. Location - City or Town, State NOV. 14, 2000 FALLSTON MARYLAND		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility EVANS FUNERAL CHAPEL - BELAIR, P.A. 21050 3 NEWPORT DRIVE FOREST HILL MARYLAND				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. COPD a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death 10 years	
	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28e. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D39099		29d. Date signed (Month, Day, Year) 11-12-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RODNEY W. H. AINS, CBMC, BALTIMORE								
State Registrar	31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature 			

ORIGINAL

Handwritten notes, mostly illegible due to fading. Some words like "Lecture" and "Notes" are faintly visible.

Handwritten notes, mostly illegible due to fading. Some words like "Lecture" and "Notes" are faintly visible.

Handwritten notes, mostly illegible due to fading. Some words like "Lecture" and "Notes" are faintly visible.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35815

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Kehne						2. Date of Death Month Day Year November 9 2000		3. Time of Death 2:50 pm		
	4a. Facility Name (If not institution, give street and number) Baltimore V. A. Medical Center						4b. City, Town, or Location of Death Baltimore		4c. County of Death n/a		
Funeral Director	5. Social Security Number 213-58-1786		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 51		8. Date of Birth Month Day Year 05-31-49		9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent										
10a. State MD		10b. County n/a		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 3115 Tynedale Avenue				10f. Zip Code 21214		10g. Citizen of What Country? USA					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: VIETNAM			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Caucasian		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electric Motor Repair				16b. Kind of Business/Industry Wisner Electric Co.			
17. Father's Name (First, Middle, Last) Walter Kehne						18. Mother's Name (First, Middle, Maiden Surname) Anna Giovannucci					
19a. Informant's Name/Relationship (Type, Print) Mrs. Charlotte Kehne						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3115 Tynedale Avenue, Baltimore, MD 21214					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount		Date 11-13		20c. Location - City or Town, State Balto., MD			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Kaczorowski Funeral Home, P.A. 1201 Dundalk Avenue, Baltimore, MD 21222					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or renal failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier  Sim Jend, MD						29c. License number P14691		29d. Date signed (Month, Day, Year) November 9, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sim Jend, MD BV AMC 10 W. Greene St. Baltimore, MD 21201											
31. Date filed (Month, Day, Year) NOV 13 2000			32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35816

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Geraldine Kelly

2. Date of Death
Month Day Year

November 5, 2000 8:20 p

3. Time of Death

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Genesis Homewood Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

215-60-5994

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Apr. 18, 1953

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

510 Beaumont

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Rowe Clothing

17. Father's Name (First, Middle, Last)

Wilbur Hebron

18. Mother's Name (First, Middle, Maiden Surname)

Kelly

19a. Informant's Name/Relationship (Type, Print)

Rodney Arnold-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 F. Aspenwood Way. Balto. MD 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arbutus Memorial Cem.

20c. Location - City or Town, State

Balto, MD

21. Signature of Funeral Service Licensed

22. Name and Address of Facility 2501 Gwynns Falls Pkwy.
Nutter Funeral Home Inc.

Baltimore, Maryland 21216

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. AIDS
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):Approximate
Interval Between
Onset and Deathyears

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D54514

29d. Date signed (Month, Day, Year)

11-7-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3007 2. Northern Parkway Baltimore MD 21214

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35817

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wiley J. Lark				2. Date of Death Month November Day 7 Year 2000				3. Time of Death 6:30AM			
	4a. Facility Name (If not institution, give street and number) 4617 Belvieu Ave.				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A			
Funeral Director	5. Social Security Number 251-26-7069		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) July 20, 1912			
	9. Birthplace (State or Foreign Country) South Carolina											
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 4617 Belvieu Ave.				10f. Zip Code 21207		10g. Citizen of What Country? USA					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Negro				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fork Lift Operator			18b. Kind of Business/Industry Eastern Product Co.				
	17. Father's Name (First, Middle, Last) Pierce Lark				18. Mother's Name (First, Middle, Maiden Surname) unk.							
	19a. Informant's Name/Relationship (Type, Print) (Wife) Mrs. Edna Lark				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4617 Belvieu Ave. Balto. Md. 21207							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Park		Date 11/13/2000		20c. Location - City or Town, State Balto. Md.					
	21. Signature of Funeral Service Licensee Joseph L. Russ				22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. UPPER G.I. BLEED								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Joseph L. Russ				29c. License number D 15634		29d. Date signed (Month, Day, Year) 11.09.00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. K. CATHENHAM MD 3509 EASTERN AVE. BALTO MD 21224												
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature [Signature]										

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35818

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Georgiana E. Lee				2. Date of Death Month Day Year October 30, 2000		3. Time of Death 5:50 a.m.	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-18-4925		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 24, 1917	9. Birthplace (State or Foreign Country) VA
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1211 Keithmont Road				10f. Zip Code 21228		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Recirculation Supervisor and Engraving		16b. Kind of Business/Industry Bureau of Printing			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) James Dunaway				18. Mother's Name (First, Middle, Maiden Surname) Clara Curry			
	19a. Informant's Name/Relationship (Type, Print) Tolford D. Lee				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1211 Keithmont RD., Balto, MD 21228			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Cem.		Date 11/6		20c. Location - City or Town, State Owings Mills, MD	
	21. Signature of Funeral Service licensee 		22. Name and Address of Facility Nutter Funeral Home Inc. 2501 Gwynns Falls Pkwy., Balto., Md 21216					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Hypertension							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier  MD				29c. License number D45708		29d. Date signed (Month, Day, Year) November, 3, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARY J. KERFUIET MD 2401 W. BELVEDERE AVE, BALT, MD 21215							
	31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35819

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Katherine J Lear

2. Date of Death

Nov 3 00

3. Time of Death

12:35 am

4a. Facility Name (If not institution, give street and number)

Fairhaven

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

216-05-9859

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept 19, 1913

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7200 3RD Avenue

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4 or 5+) 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

executive secretary

18b. Kind of Business/Industry

insurance

17. Father's Name (First, Middle, Last)

Frederick C. Joram

18. Mother's Name (First, Middle, Maiden Summa)

Emma A. Kirner

19a. Informant's Name/Relationship (Type, Print)

Charles Joram Jr nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2203 Sunset Drive Eldersburg, MD 21784

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Breast Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Vascular Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☒ Nursing Home

5 ☐ Residence

8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ernestine Wright, MD

29c. License number

DS2740

29d. Date signed (Month, Day, Year)

11/03/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ernestine Wright

CATONSVILLE, MD

31. Date filed (Month, Day, Year)

Nov 13 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Roger Lee Leaman

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35820

amend item 23a,27, 28a,bc,d,e,f per me G790 12/12/00 y **Certificate of Death**

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROGER LEE LEAMAN				2. Date of Death Month November Day 3 Year 2000				3. Time of Death 12:47 P.M.	
	4a. Facility Name (If not institution, give street and number) Northbound Route 13 by-pass near Johnson Road Salisbury				4b. City, Town, or Location of Death Salisbury				4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 177-64-3091	6. Sex 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 34 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct 22, 1966		9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent				10a. State Pennsylvania		10b. County Lancaster		10c. City, Town or Location Clay Township: Ephrata	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 1685 W Main Street, Apt #2		10f. Zip Code 17522		10g. Citizen of What Country? USA		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Press Assistant		16b. Kind of Business/Industry Publishing Company				
17. Father's Name (First, Middle, Last) Glenn M. Leaman				18. Mother's Name (First, Middle, Maiden Surname) Jane Sauder						
19a. Informant's Name/Relationship (Type, Print) Glenn M. Leaman (Father)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3234 Glengreen Drive, Lancaster, Pennsylvania 17601						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Yorktowne Caskets, Inc. Cremation Service		Date 11/9/00		20c. Location - City or Town, State York, York Co., PA				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stradling Funeral Homes, Inc. 201 Church Avenue, P.O. Box 92, Ephrata, PA 17522						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE INJURIES Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) by truck						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 11/3/00		28b. Time of Injury 12:20 P M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred pedestrian struck by truck		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street				28f. Location (Street and Number or Rural Route Number, City or Town, State) Salisbury, Md Rt. 13 bypass,						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) November 4, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TIMS, M.D. 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35821

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VIRGINIA MOBLEY						2. Date of Death Month Day Year NOVEMBER 7, 2000		3. Time of Death 6:45pm														
	4a. Facility Name (If not institution, give street and number) SANDTOWN WINCHESTER NURSING HOME						4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA														
Funeral Director	5. Social Security Number 244-34-1544		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.														
	8. Date of Birth (Month, Day, Year) JUNE 1, 1927		9. Birthplace (State or Foreign Country) NC		10a. State MD		10b. County NA		10c. City, Town or Location BALTIMORE														
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1000 N. GILMOR STREET		10f. Zip Code 21217		10g. Citizen of What Country? USA																
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN																
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry WIRE COMPANY																		
	17. Father's Name (First, Middle, Last) DOC MOBLEY				18. Mother's Name (First, Middle, Maiden Surname) LULA MOBLEY																		
	19a. Informant's Name/Relationship (Type, Print) HENRY EASTER (BROTHER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 835 N. BENTALOU STREET BALTIMORE, MD 21216																		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY		Date 11/11/00		20c. Location - City or Town, State LANSDOWNE, MD																
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217																		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
	<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>PNEUMONIA</td> <td>Approximate Interval Between Onset and Death DAYS</td> </tr> <tr> <td>b.</td> <td>LUNG CANCER</td> <td>MONTHS</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	PNEUMONIA	Approximate Interval Between Onset and Death DAYS	b.	LUNG CANCER	MONTHS	c.			d.		
	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	PNEUMONIA	Approximate Interval Between Onset and Death DAYS																			
b.		LUNG CANCER	MONTHS																				
c.																							
d.																							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																							
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined																							
28a. Date of Injury (Month, Day Year)																							
28b. Time of Injury M																							
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																							
28d. Describe how injury occurred																							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																							
28f. Location (Street and Number or Rural Route Number, City or Town, State)																							
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																							
29b. Signature and title of certifier  M. VASANTHAKUMARI MD																							
29c. License number D42510																							
29d. Date signed (Month, Day, Year) NOV-08, 2000																							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. VASANTHAKUMARI MD 821 N. EOTAWSP # 407, MD21201																							
31. Date filed (Month, Day, Year) NOV 13 2000																							
32. Registrar's Signature 																							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35822

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mabel Meadows				2. Date of Death Month Day Year Nov. 08, 2000				3. Time of Death 8:45am	
	4a. Facility Name (If not institution, give street and number) Harford Gardens Nursing Home				4b. City, Town, or Location of Death Baltimore				4c. County of Death NA	
Funeral Director	5. Social Security Number 240-48-8353		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) 09-14-23		9. Birthplace (State or Foreign Country) NC		10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1903 E. North Avenue				10f. Zip Code 21213		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic				16b. Kind of Business/Industry somelse home	
	17. Father's Name (First, Middle, Last) Eddie Thomas				18. Mother's Name (First, Middle, Maiden Surname) Viola Allen				Apt. # 1	
	19a. Informant's Name/Relationship (Type, Print) Charmin Stanfield				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6190 Northwood Drive Baltimore, Maryland 21212					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Pk. Cem. 11-13-2000 Arbutus, MD				20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute myocardial infarction Due to (or as a consequence of): b. Coronary artery disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death minutes years					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCVD				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number D37573		
29d. Date signed (Month, Day, Year) November 9, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jef Zibell MD 7220 Park Heights Ave Baltimore MD 21208						
31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 22 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35823

Baltimore, Maryland 21215-0020

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Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) DELORES		2. Date of Death Month NOVEMBER Day 09 Year 2000		3. Time of Death 6:09 PM	
4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death NA	
5. Social Security Number 219-32-7949	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 05-17-36
9. Birthplace (State or Foreign Country) MD		Usual Residence of Decedent			
10a. State MD	10b. County NA	10c. City, Town or Location Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 732 Wharton Court		10f. Zip Code 21205		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade College (1-4 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lab Technician	
16b. Kind of Business/Industry Johns Hopkins Hosp.		17. Father's Name (First, Middle, Last) Charles Desmond		18. Mother's Name (First, Middle, Maiden Surname) Mamie Francis	
19a. Informant's Name/Relationship (Type, Print) Delores R. Miller		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1212 Autumn Leaves Court Baltimore, MD. 21202			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem. 11-15-2000 Baltimore Co.		20c. Location - City or Town, State MD.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ISCHEMIC BOWEL Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last END STAGE RENAL DISEASE Due to (or as a consequence of):		Approximate Interval Between Onset and Death 3 DAYS			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ISCHEMIC CARDIOMYOPATHY END STAGE RENAL DISEASE					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number RES-000		29d. Date signed (Month, Day, Year) NOVEMBER 10, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUSAN MANI JOHNS HOPKINS HOSPITAL					
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 			

2003 NOV 13 PM 2:52

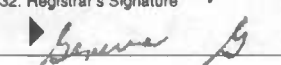
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35824

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ETHEL P. Mosby				2. Date of Death Month 11 Day 9 Year 00				3. Time of Death 11:43 AM	
	4a. Facility Name (If not institution, give street and number) Howard County Hosp. Inc				4b. City, Town, or Location of Death Columbia				4c. County of Death Howard	
Funeral Director	5. Social Security Number 217-14-9909		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 82 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	6. Date of Birth (Month, Day, Year) Dec. 23 1917		9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Sparks	
Usual Residence of Decedent										
10a. State MD		10b. County Baltimore		10c. City, Town or Location Sparks				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 827 E. Quaker Bottom Rd.				10f. Zip Code 21152				10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) n/a				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Driver				16b. Kind of Business/Industry Transportation		
17. Father's Name (First, Middle, Last) Joseph Speed						18. Mother's Name (First, Middle, Maiden Surname) Bertha A. Whye				
19a. Informant's Name/Relationship (Type, Print) Barbara J. Mosby/daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 827 E. Quaker Bottom Rd., Sparks, MD 21152				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Luke United Meth. Ch. Cem.				20c. Location - City or Town, State Hereford, MD		
21. Signature of Funeral Director  Michael J. Plagle				22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypotension Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Approximate Interval Between Onset and Death hours Days										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier  Jeffrey Kniz		29c. License number D36786		29d. Date signed (Month, Day, Year) 11-9-00			
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Jeffrey Kniz M.D., 6528 Ocean Shore Lane, Columbia MD										
31. Date filed (Month, Day, Year) NOV 13 2000			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 66760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35825

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) LISA MASON		2. Date of Death Month November Day 06 Year 2000		3. Time of Death 10:52 A.M.	
4a. Facility Name (If not institution, give street and number) 401 North Eutaw Street, Apartment 215		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
5. Social Security Number 215-84-2693		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.	
8. Date of Birth (Month, Day, Year) NOV. 22, 1960		9. Birthplace (State or Foreign Country) MARYLAND		10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE	
10d. Street and Number 401 N. EUTAW STREET, APARTMENT 215		10e. Zip Code 21202		10f. Citizen of What Country? U.S.A.	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SORTER	
16b. Kind of Business/Industry BANKS		17. Father's Name (First, Middle, Last) PAUL BEY		18. Mother's Name (First, Middle, Maiden Surname) DIANA MASON	
19a. Informant's Name/Relationship (Type, Print) DIANA M. GRAHAM-MOTHER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 SEAGULL AVE BALTIMORE, MARYLAND 21225			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MOUNT ZION CEMETERY		20c. Location - City or Town, State 11-11-00 LANSDOWNE, MD.	
21. Signature of Funeral Service Licensee <i>Lewis T. Gwynn</i>		22. Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 4517 PARKHEIGHTS AVE. BALTO. MD. 21215-6393			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) found: 11/6/00		28b. Time of Injury found: 10:30 A M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unknown		28e. Location (Street and Number or Rural Route Number, City or Town, State) 401 N. Eutaw Street Baltimore, Maryland	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Regina D. O'Neil</i>		29c. License number O.C.M.E.	
29d. Date signed (Month, Day, Year) November 07, 2000		30. Name and address of person who completed causa of death (Item 23e) (Type, Print) Maryann A. Korol 111 Penn Street, Baltimore, Maryland 21201			
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature <i>Benjamin B. Sparks</i>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 35826

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Irene A. Metz</i>						2. Date of Death Month <i>Nov</i> Day <i>9</i> Year <i>2000</i>		3. Time of Death <i>9:25 AM</i>		
	4a. Facility Name (If not institution, give street and number) <i>Genesis - Long Green Center</i>						4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death		
Funeral Director	5. Social Security Number <i>212-32-46006</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>102</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>June 20, 1898</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>		
	Usual Residence of Decedent						10a. State <i>md</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Parkville</i>
To Be Completed by Funeral Director		10e. Street and Number <i>7711 Park Dr.</i>				10f. Zip Code <i>21234</i>		10g. Citizen of What Country? <i>USA</i>			
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>14</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Nurse</i>		16b. Kind of Business/Industry <i>St. Gabriels</i>			
		17. Father's Name (First, Middle, Last) <i>Phillip A. Kahmer</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Anna S. Condor</i>					
		19a. Informant's Name/Relationship (Type, Print) <i>Doris Walther</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3637 Anderson Lane Jarroville Md. 21084</i>					
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Dulaney Valley Mem. Gdus.</i>		Date <i>Nov. 11 2000</i>		20c. Location - City or Town, State <i>Timonium, Maryland</i>			
		21. Signature of Funeral Service Licensee <i>Heather S. Wells</i>				22. Name and Address of Facility <i>Evans Funeral Chapel</i> <i>8800 Harford Rd. Baltimore, Md 21234</i>					
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Stroke</i> Due to (or as a consequence of): b. <i>Atrial Arrhythmia</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Physician /Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Thoracic Aneurysm</i> <i>Hypothyroidism</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
Medical Certification: To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of Certifier <i>[Signature]</i>		29c. License number <i>D17118</i>		29d. Date signed (Month, Day, Year) <i>Nov 9, 2000</i>			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Paul Schaefer M.D. 115 E. Melrose Ave 21212</i>									
State Registrar		31. Date filed (Month, Day, Year) <i>NOV 13 2000</i>		32. Registrar's Signature <i>[Signature]</i>							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35827

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM TILGHMAN MEYER

2. Date of Death

Month Day Year
NOV. 9, 2000

3. Time of Death

0817

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-07-6506

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
1/1/1907

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6825 QUEENS FERRY ROAD

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CARPENTER

16b. Kind of Business/Industry

BETHLEHEM STEEL

17. Father's Name (First, Middle, Last)

GEORGE WALTER MEYER

18. Mother's Name (First, Middle, Maiden Surname)

SARAH PUGH

19a. Informant's Name/Relationship (Type, Print)

GEORGE T. MEYER SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6825 QUEENS FERRY ROAD BALTIMORE, MD 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKWOOD CEMETERY

Date

11/13/00

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.
8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL VALLE 1576 MERRITT BLVD. WHITE 14 BALTIMORE, MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

NOV 13 2000

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Doris McCaskill

State of Maryland / Department of Health and Mental Hygiene

amend item 23a,b 28a-f per me G789 11/29/00 yf
amend item 23a,27,28a,bc,d,ef, per me G789 11/27/00 yf

Certificate of Death

Reg. No.

00 35828

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Doris Jean McCaskill				2. Date of Death Month Day Year November 08, 2000		3. Time of Death 1644 pm		
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 220-84-6165	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 40 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year May 24, 1960		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 432 E. Federal St.			10f. Zip Code 21202		10g. Citizen of What Country? USA			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Afro-American		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Robert McCaskill				18. Mother's Name (First, Middle, Maiden Surname) Dorsine Hickmon				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Ms. Antoinette Bradford				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 432 E. Federal St. Balto. Md. 21202				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion		20c. Date 11/17/2000		20d. Location - City or Town, State Lansdowne, Md.		
	21. Signature of Funeral Service Licensee Joseph L. Russ				22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC INTOXICATION INTRACEREBRAL HEMORRHAGE Due to (or as a consequence of): b. ENDOCARDITIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 11/8/00		28b. Time of Injury unknown M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unknown
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) unknown				28f. Location (Street and Number or Rural Route Number, City or Town, State) unknown				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier J. L. Lapon				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) November 09, 2000		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LAPON Locke, MD 111 Penn Street, Baltimore, Maryland 21201								
	31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35829

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KATHERINE M. MARHENKE				2. Date of Death Month Day Year November 11 2000			3. Time of Death 10:00 am		
	4a. Facility Name (If not institution, give street and number) ER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON			4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 220-05-1628		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) June 24, 1916		9. Birthplace (State or Foreign Country) Md.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md.		10b. County Baltimore		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 2426 Bradford Rd.				10f. Zip Code 21234			10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home maker			16b. Kind of Business/Industry Own home		
	17. Father's Name (First, Middle, Last) George Koenig				18. Mother's Name (First, Middle, Maiden Surname) Mary E. Smith					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. Al Frizzell/grand son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3308 Summit Ave. Baltimore, Md. 21234					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment				20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial			20c. Location - City or Town, State Timonium, Md.		
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Intracranial Bleed Due to (or as a consequence of): b. Stroke Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure C.O.P.D.									
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier M. Schwartz MD				29c. License number D-44728			29d. Date signed (Month, Day, Year) 11/11/00		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MITCHELL SCHWARTZ 6569 N. Charles St. Ste 601									
	31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature Benjamin S. Sparks					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 10e per fh G789 11/13/00 yf

Certificate of Death

Reg. No.

00 35830

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BEATRICE MODABER.				2. Date of Death Month Day Year November 9 2000		3. Time of Death 7:30 AM	
	4a. Facility Name (If not institution, give street and number) Lorien Nursing Home				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard	
Funeral Director	5. Social Security Number 212-32-1081		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 28, 1929	
	10a. State Maryland		10b. County Howard		10c. City, Town or Location Columbia		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Usual Residence of Decedent								
10e. Street and Number 6334 Cedar Lane				10f. Zip Code 21044		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Secretary			16b. Kind of Business/Industry Communication Education	
17. Father's Name (First, Middle, Last) George B. Wilson					18. Mother's Name (First, Middle, Maiden Surname) Ethel Gertrude Sarah York			
19a. Informant's Name/Relationship (Type, Print) Pamela R. Crowe / daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 179 Vinson Ridge Lane, Clayton, North Carolina			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Columbia Mem. Park		Date Nov. 13, 2000		20c. Location - City or Town, State Columbia, Maryland	
21. Signature of Funeral Service Licensee <i>[Signature]</i> WNV142					22. Name and Address of Facility Witzke Funeral Home, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045			
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Squamous Cell Cancer Floor of Mouth Due to (or as a consequence of): Smoker Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>					29c. License number D31575		29d. Date signed (Month, Day, Year) November 9, 2000	
30. Name and address of person who completed cause of death (Item 23d) (Type, Print) KOLOD ALBERTZ 9501 Old Annapolis Rd Ellicott City, MD 21042								
31. Date filed (Month, Day, Year) NOV 13 2000			32. Registrar's Signature <i>[Signature]</i>					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 35831

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Alice Mackin

2. Date of Death
Month Day Year

November 5 2000

3. Time of Death

940 AM

4a. Facility Name (If not institution, give street and number)

Upper Chesapeake Medical Center

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

219-12-6152

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
7/27/1924

9. Birthplace (State or Foreign Country)

Butler, MD

Usual Residence of Decedent

10a. State

Md

10b. County

Harford

10c. City, Town or Location

Jarrettsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3413 North Furnace Road

10f. Zip Code

21084

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 years

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Her own Home

17. Father's Name (First, Middle, Last)

Carl Grason Treadwell

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Cooper

19a. Informant's Name/Relationship (Type, Print)

Calvin L. Mackin (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3413 North Furnace Rd. Jarrettsville, Md 21084

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Cemetery 11/10/00 Timonium

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

E.F. Lassahn

22. Name and Address of Facility

E.F. Lassahn Funeral Home
11750 Belair Rd. Kingsville, Md 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Basil Karakash, M.D.

29c. License number

D0047813

29d. Date signed (Month, Day, Year)

November 5 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BASIL KARAKASH

39 Churchville Rd. Suit 200

Bel Air MD 21014

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

Basil Karakash

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

Margaret A. Mackin

State
Registrar

2009 NOV 13 AM 11:33

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35832

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VERA LYLE MILLER

2. Date of Death
Month Day Year

NOV 7 2000 11:59 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

UPPER CHESAPEAKE MED CENTER

4b. City, Town, or Location of Death

BELAIR

4c. County of Death

HARFORD

5. Social Security Number

218-18-8498

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

6/19/1922

9. Birthplace (State or Foreign Country)

Balto. MD

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Abingdon

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20 box Hill S. Parkway APT 201

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
7 yearsCollege (1-4 or 5+)
N/A16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Her own Home

17. Father's Name (First, Middle, Last)

William Clifford Adkins

18. Mother's Name (First, Middle, Maiden Surname)

Martha Roxie Carver

19a. Informant's Name/Relationship (Type, Print)

H. Edward Miller (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 Drewberry Way BelAir, MD 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BelAir Memorial Gardens

Date

11/11/00

20c. Location - City or Town, State

BelAir. MD

21. Signature of Funeral Service Licensee

E. F. Lassahn

22. Name and Address of Facility

E.F. Lassahn Funeral Home
11750 Belair Rd. Kingsville, Md 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

s. METASTATIC CANCER

Due to (or as a consequence of):

b. CANCER BREAST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. G. Prabhakar MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

NOV 7, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. G. Prabhakar 707 728 BELAIR MD BELAIR MD 21014

31. Date filed (Month, Day, Year) - - -

NOV 13 2000

32. Registrar's Signature

Jennifer B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35833

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALFRED MYERS				2. Date of Death Month Day Year November 7 2000		3. Time of Death 1030 AM	
	4a. Facility Name (If not institution, give street and number) 218 EARLS ROAD				4b. City, Town, or Location of Death CHASE		4c. County of Death BALTIMORE CO	
Funeral Director	5. Social Security Number 219-34-2075		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs		8. Date of Birth (Month, Day, Year) MARCH 3 1936	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location CHASE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 218 EARLS ROAD			
	10f. Zip Code 21220				10g. Citizen of What Country? U.S.A.			
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) AUTO MACH.		16b. Kind of Business/Industry TRUCK DRIVER			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) RUSSELL C MYERS				18. Mother's Name (First, Middle, Maiden Surname) DORA V MYERS			
	19a. Informant's Name/Relationship (Type, Print) Alfred D. Myers Sr./Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48 Akin Circle, Baltimore Maryland 21220			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SHARP STREET U.M.C		Date 11-11-00		20c. Location - City or Town, State CHASE, MARYLAND	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 321 S PHILADELPHIA BLVD ABERDEEN, MARYLAND 21001					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 2.5 years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier  Deputy				29c. License number D18667		29d. Date signed (Month, Day, Year) November 9, 2000	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PHILIP MITELLO, MD Shock Trauma 22 S. Greene St. Baltimore, Md 21201							
	31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35834

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nathaniel McDaniels						2. Date of Death Month Day Year Nov 04 00			3. Time of Death 11:07 PM		
	4a. Facility Name (If not institution, give street and number) Bon Secours Hospital						4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A		
Funeral Director	5. Social Security Number 213-03-6726		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Aug. 22, 1910	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent											
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 4803 The Alameda						10f. Zip Code 21239			10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 2						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Expenditer Supervisor			16b. Kind of Business/Industry United States Postal Service			
17. Father's Name (First, Middle, Last) Edward McDaniels						18. Mother's Name (First, Middle, Maiden Surname) Ida Logan						
19a. Informant's Name/Relationship (Type, Print) Sarah E. McDaniels						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4803 The Alameda, Balto., MD 21239						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Park			Date 11/10		20c. Location - City or Town, State Baltimore, MD			
21. Signature of Funeral Service Licensee Herbert E. Nutter						22. Name and Address of Facility Nutter Funeral Home Inc. 2501 Gwynns Falls Pkwy., Balto., MD 21216						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac arrhythmia Due to (or as a consequence of): atherosclerotic heart disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dementia										Approximate Interval Between Onset and Death 15 MIN 1 day	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier K. DESAI M		29c. License number D 36494		29d. Date signed (Month, Day, Year) 11/10/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. DESAI M 4660 Wilkows Ave Baltimore MD 21229												
State Registrar		31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35835

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CATHERINE VENETTA Mc Coy		2. Date of Death Month Oct Day 28 Year 2000		3. Time of Death 6:15P
	4a. Facility Name (If not institution, give street and number) 9811 Southall Road		4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 251 38 4482	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth Month Day Year Oct 23, 1921		9. Birthplace (State or Foreign Country) South Carolina		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Randallstown		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 9811 Southall Road		10f. Zip Code 21133		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 years College (1-4 or 5+)		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Educator		16b. Kind of Business/Industry South Carolina PUBLIC SCHOOLS		
	17. Father's Name (First, Middle, Last) George Alton William		18. Mother's Name (First, Middle, Maiden Surname) Rebecca Sutton		
	19a. Informant's Name/Relationship (Type, Print) Thomaseena Timpson / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9811 Southall Road Randallstown, Maryland 21133		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		20c. Location - City or Town, State Woodlawn, Maryland
	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility CHATHAM - HARRIS Funeral Home 5240 REISTERSTOWN ROAD BALTIMORE, MD 21215		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) Metastatic Breast Cancer Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number 018320	29d. Date signed (Month, Day, Year) 10/31/00
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Fetting MD. Johns Hopkins Oncology Ctr Baltimore MD 21231					
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature [Signature]			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35836

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ada Lee Nuckols				2. Date of Death Month Day Year November 10, 2000				3. Time of Death 12:25 AM	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-28-2526		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) March 22, 1932		9. Birthplace (State or Foreign Country) North Carolina	
	Usual Residence of Decedent				10a. State Maryland				10b. County Baltimore	
To Be Completed by Funeral Director	10c. City, Town or Location Middle River				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	10e. Street and Number 2124 Vailthorn Road				10f. Zip Code 21220				10g. Citizen of What Country? U.S.A.	
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembler				16b. Kind of Business/Industry Electronics	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Plato Gaddy				18. Mother's Name (First, Middle, Maiden Surname) Elsie McCormick					
	19a. Informant's Name/Relationship (Type, Print) Marshall Nuckols (husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2124 Vailthorn Road, Baltimore, Maryland 21220					
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem. Gardens				20c. Location - City or Town, State 11/13/2000 Baltimore, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bruzdinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) a. Ischemic Bowel Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 10 Days	
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Congestive Heart Failure Renal Artery Stenosis								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier William P. Warren MD				29c. License number D 0055331	
	29d. Date signed (Month, Day, Year) November 10, 2000				29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Warren MD 9000 Franklin Square Drive Baltimore Maryland 21237					
State Registrar	31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature 					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35837

Certificate of Death

Reg. No.

1. Decedent's Name (First, Middle, Last) Barbara O'Neal		2. Date of Death Month Day Year NOVEMBER 03, 2000		3. Time of Death 06:47 AM	
4a. Facility Name (If not institution, give street and number) 3711 LIBERTY HEIGHTS AVENUE		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
5. Social Security Number 218-56-1406		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.	
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore	
10e. Street and Number 3711 Liberty Heights Avenue		10f. Zip Code 21215		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Jerry O'Neal Jr.		18. Mother's Name (First, Middle, Maiden Surname) Jessie L. Lesane			
19a. Informant's Name/Relationship (Type, Print) Dorothy Owens-Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3904 Bateman Ave., Balto, Md 21216			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Park		20c. Location - City or Town, State 10/9 Baltimore, MD	
21. Signature of Funeral Service Licensee Herbert E. Nutter		22. Name and Address of Facility Nutter Funeral Home Inc. 2501 Gwynns Falls Pkwy, Balto., MD 21216			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) SCENE			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Theresa M. King		29c. License number OCME		29d. Date signed (Month, Day, Year) NOVEMBER 03, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature [Signature]			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

jhm
NATESHA
PENICK

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


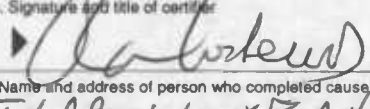

State of Maryland / Department of Health and Mental Hygiene

00 35838

amend item 23a,27,28a,b,c,d,e,f per me G789 11/14/00

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Natesha Penick		2. Date of Death Month Day Year NOVEMBER 06, 2000		3. Time of Death 00:21 AM												
	4a. Facility Name (If not institution, give street and number) 1132 NORTH AVENUE		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA												
Funeral Director	5. Social Security Number 220-39-0282	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.												
	8. Date of Birth (Month, Day, Year) 10-02-93		9. Birthplace (State or Foreign Country) MD														
Usual Residence of Decedent																	
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore													
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																	
10e. Street and Number 1132 E. North Avenue		10f. Zip Code 21202		10g. Citizen of What Country? USA													
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:													
14. Race - American Indian, Black, White, etc. Specify: Black																	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2nd Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Child		16b. Kind of Business/Industry Child													
17. Father's Name (First, Middle, Last) Clem Penick		18. Mother's Name (First, Middle, Maiden Surname) Jacqueline Chapman															
19a. Informant's Name/Relationship (Type, Print) Geneva Brown		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 6679 Springmill Circle Baltimore, Maryland															
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Mem. Pk. Cemetery		20c. Location - City or Town, State 11-11-2000 Randallstown MD													
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue															
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. SMOKE INHALATION</td> <td rowspan="4"> Due to (or as a consequence of): </td> <td rowspan="4"></td> </tr> <tr> <td>b.</td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. SMOKE INHALATION	Due to (or as a consequence of):		b.	c.	d.					
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. SMOKE INHALATION	Due to (or as a consequence of):															
	b.																
	c.																
	d.																
<table border="1"> <tr> <td colspan="2"> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. </td> <td colspan="2"> 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown </td> </tr> <tr> <td colspan="2"></td> <td colspan="2"> 24e. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No </td> </tr> <tr> <td colspan="2"></td> <td colspan="2"> 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No </td> </tr> </table>						Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24e. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown															
		24e. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No															
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No															
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE															
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 11/6/00		28b. Time of Injury 12:12 M													
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred fire victim of house													
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1132 North Ave., Baltimore, MD.													
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
29b. Signature and title of certifier 		29c. License number OCME		29d. Date signed (Month, Day, Year) NOVEMBER 06, 2000													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. L. Brown, MD 111 Penn Street, Baltimore, Maryland 21201																	
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 455-5555.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35839

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Alice Petrecca

2. Date of Death

November 13, 2000

3. Time of Death

3:06 a.m.

4a. Facility Name (If not institution, give street and number)

Ivy Hall Geriatric Center

4b. City, Town, or Location of Death

Middle River

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

220-09-8285

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 1, 1917

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

33 South Hawthorne Road

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Robert Howell

18. Mother's Name (First, Middle, Maiden Surname)

Alice Huntley

19a. Informant's Name/Relationship (Type, Print)

Phyllis A. Bolling (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7310 Tred Avon Road, Baltimore, Maryland 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gardens

Date

11/16/2000 Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home, P.A.

1407 Old Eastern Avenue, Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE LUNG DISEASE

25 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D17728

29d. Date signed (Month, Day, Year)

11-13-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAYIN OUNG, M.D., 8022 BELAIR ROAD

BALTIMORE, Md. 21236

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

B Spauld

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35840

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edith May Palmer						2. Date of Death Month Day Year November 10, 2000		3. Time of Death 6:55 AM		
	4a. Facility Name (If not Institution, give street and number) 404 Northway						4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A		
Funeral Director	5. Social Security Number 219-14-2008		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 100 Yrs.		8. Date of Birth (Month, Day, Year) June 10, 1900		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 404 Northway				10f. Zip Code 21218		10g. Citizen of What Country? USA					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Stenographer		16b. Kind of Business/Industry Railroad					
17. Father's Name (First, Middle, Last) George Coburn						18. Mother's Name (First, Middle, Maiden Surname) Laura Burns					
19a. Informant's Name/Relationship (Type, Print) Mrs. Melva Green / Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Northway Baltimore, MD 21218							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. Location - City or Town, State 11/13/00 Baltimore, Maryland					
21. Signature of Funeral Service Licensee Christina L. Hilton <i>Christina L. Hilton</i>				22. Name and Address of Facility Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Coronary Heart Failure Due to (or as a consequence of): Coronary Artery Disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death 6 mo.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 11-10-2000		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>William M. Smith M.D.</i>		29c. License number D10809		29d. Date signed (Month, Day, Year) 11-10-2000			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) W. M. Smith M.D. 1900 E. NORTHERN PKWY, BALTO MD											
31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature <i>Sparks</i>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35841

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wilbur F. Perkins						2. Date of Death Month NOVEMBER Day 6 Year 2000		3. Time of Death 2:40		
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital						4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City		
Funeral Director	5. Social Security Number 213-26-2637		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) May 24, 1930		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland			10b. County Baltimore City			10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 3414 Wilkens Avenue						10f. Zip Code 21229		10g. Citizen of What Country? United States			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates 9-20-1959			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Police Officer Railroad			16b. Kind of Business/Industry Railroad		
17. Father's Name (First, Middle, Last) Hugh Lester Perkins						18. Mother's Name (First, Middle, Maiden Surname) Hazel Mae Atkinson					
19a. Informant's Name/Relationship (Type, Print) Erika A. Perkins-Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3414 Wilkens Avenue, Baltimore, Maryland 21229					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)						20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery			20c. Location - City or Town, State 11-10-00 Baltimore, Maryland		
21. Signature of Funeral Service Licensee Lisa S. Jefferson						22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. myocardial infarction Due to (or as a consequence of): b. coronary artery disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 1 hour 10 years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End-stage Renal Disease, Dialysis, Diabetes, Hypertension										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier DR [Signature] MD						29c. License number BG5846998		29d. Date signed (Month, Day, Year) November 06, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Agnes Hospital Rob Greenhalgh MD 900 Calver Avenue Baltimore, Md. 21229											
31. Date filed (Month, Day, Year) NOV 13 2000						32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Perkins, Wilbur F

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35842

AMEND#1 PER MD. G789 11-13-2000 JAB

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

~~Lucille Parsons~~ LUCILLE PARSON

2. Date of Death

Month
11

Day

Year
2000

3. Time of Death

3:02 AM

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

BALTIMORE CITY

Funeral
Director

5. Social Security Number

212-34-6522

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 30, 1928

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1003 Ashburton Street

10f. Zip Code

21216

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
African-American15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

2 years

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Licensed Practical Nurse

16b. Kind of Business/Industry

medical profession

17. Father's Name (First, Middle, Last)

Saylor Stephens

18. Mother's Name (First, Middle, Maiden Surname)

Flossie Dickerson

19a. Informant's Name/Relationship (Type, Print)

William Parson- Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1003 Ashburton Street, Baltimore MD 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Crownsville VA Cemetery

Date

11/6/00

20c. Location - City or Town, State

Crownsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

2140 N. Fulton Avenue

Joseph H. Brown JR Funeral Home Baltimore, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Malignant Arrhythmia
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

30 min

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Thrombosed Mitral Valve Prosthesis

Coronary Artery Disease

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

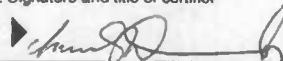
(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

 Resident Surgeon

29c. License number

D47930

29d. Date signed (Month, Day, Year)

11/1/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles S. Drummond, III, M.D. 22 S. Green St Baltimore, MD 21201

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

 RegistrarState
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
2024.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35843

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES ROSS		2. Date of Death Month November Day 9 Year 2000		3. Time of Death 3:07 P.M.
	4a. Facility Name (If not institution, give street and number) GILCHRIST NURSING CENTER (G.B.M.C.)		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 212-36-6036	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) APRIL 9, 1940		9. Birthplace (State or Foreign Country) MARYLAND		
Usual Residence of Decedent					
10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 3912 W. NORTHERN PARKWAY APT. B3			10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. BLACK		Specify:			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FENCE WORKER		16b. Kind of Business/Industry FENCING
17. Father's Name (First, Middle, Last) ERNEST ROSS			18. Mother's Name (First, Middle, Maiden Surname) ADDIE TYLER		
19a. Informant's Name/Relationship (Type, Print) PRISCILLA ROSS-WIFE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3912 W. NORTHERN PARKWAY BALTO. MD. 21215		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MOUNT ZION CEMETERY		20c. Location - City or Town, State 11/13/00 LANSDOWNE, MD.	
21. Signature of Funeral Service Licensee <i>Lewis T. Gwynn</i> LEWIS T. GWYNN			22. Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 4517 PARKHEIGHTS AVE. BALTO. MD. 21215-6393		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Liver cancer Due to (or as a consequence of): b. Hepatitis C Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death year years					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Hospice			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number D0051926		29d. Date signed (Month, Day, Year) Nov 8, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen M. Gordon MD 6601 N. Charles St, Baltimore MD 21204					
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature <i>[Signature]</i>			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 35844

Physician (Medical Examiner)	1. Decedent's Name (First, Middle, Last) Marion Ransom				2. Date of Death Month Day Year November 3, 2000				3. Time of Death 12:40p.m.			
	4a. Facility Name (If not institution, give street and number) Genesis ElderCare Randallstown Baltimore				4b. City, Town, or Location of Death N/A				4c. County of Death N/A			
Funeral Director	5. Social Security Number 215-10-0910		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Jan. 21, 1907	
	9. Birthplace (State or Foreign Country) MD											
Usual Residence of Decedent												
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 9809 Winands Road						10f. Zip Code 21133		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher				16b. Kind of Business/Industry Balto. City Public Schools				
17. Father's Name (First, Middle, Last) John P. Wilson						18. Mother's Name (First, Middle, Maiden Surname) Corina Grooms						
19a. Informant's Name/Relationship (Type, Print) daughter Jacqueline Johnson Ransom						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9809 Winands RD., Balto, MD 21133						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Western Star				Date 11/8		20c. Location - City or Town, State Catonsville, MD		
21. Signature of Funeral Service Licensee Herbert Nutter				22. Name and Address of Facility Nutter Funeral Home Inc. 2501 Gwynns Falls Pkwy., Balto., Md 21216								
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
Immediate Cause (Final disease or condition resulting in death) a. PROBABLE MYOCARDIAL INFARCTION 2 10 min Due to (or as a consequence of): b. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE > 20 yrs Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____												
23f. Approximately Interval Between Onset and Death												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CEREBROVASCULAR ACCIDENT												
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown												
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier Adesa ATTENDING				29c. License number D 40390				29d. Date signed (Month, Day, Year) NOVEMBER 8, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.R. DESAL, MD; 23 CROSSROADS DRIVE, #325, OWINGS MILLS, MD 21117												
31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature [Signature]								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35845

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CARROLL MORLEY YOUNG RILEY				2. Date of Death Month Day Year November 5, 2000		3. Time of Death 5:35 PM	
	4e. Facility Name (If not institution, give street and number) 209 Cedarcroft Road				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-16-6944		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Oct 21, 1921	
	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore City		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 209 Cedarcroft Road				10f. Zip Code 21212		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 yrs College (1-4 or 5+) 2 yrs				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Residence		
17. Father's Name (First, Middle, Last) Harry Nash Young				18. Mother's Name (First, Middle, Maiden Surname) Beatrice Josephine Nolan				
19a. Informant's Name/Relationship (Type, Print) Eugene J. Riley, M.D. (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 Cedarcroft Road, Baltimore, Maryland 21212				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery		20c. Location - City or Town, State 11/8/2000 Homeland, Maryland		
21. Signature of Funeral Service Director Martin D. Lawson				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC COLON CARCINOMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Harry Josephine M.D.		29c. License number D26637		
				29d. Date signed (Month, Day, Year) 11/6/00				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Harry Josephine, M.D., Osler Medical Center, Towson, Maryland 21204								
31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature [Signature]				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35846

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ARTHALIA E. SIMON

2. Date of Death

Month

Day

Year

November 10 2000

3. Time of Death

11:54 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

NA

5. Social Security Number

220-20-8055

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month Day Year

SEPT. 28, 1924

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

5100 WOOLVERTON AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

AFRICAN

AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10th

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEKEEPING

16b. Kind of Business/Industry

HOSPITAL

17. Father's Name (First, Middle, Last)

BRUCE HILL

18. Mother's Name (First, Middle, Maiden Surname)

MARY DABNEY

19a. Informant's Name/Relationship (Type, Print)

ORA H. DEAN (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

110-43 166th STREET JAMAICA, NY 11433

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUTUS MEM. PARK

Date

11/16/00 BALTIMORE, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WYLIE FUNERAL HOME PA

638 N. GILMOR STREET BALTIMORE, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonitis

Due to (or as a consequence of):

2 weeks

b. AIDS

Due to (or as a consequence of):

unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary emboli

Bronchopleural fistula

Disseminated intravascular coagulation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Karen Weber DO PGY-2

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

November 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karen Weber, DO. Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

Benny S. Sparks

D

State
Registrar

Simon

Patient known as Arthalia

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35847

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Juanita Smith		2. Date of Death Month November Day 8 Year 2000		3. Time of Death 1052
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore City		4c. County of Death NA
Funeral Director	5. Social Security Number 218-44-0749	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months 07 Days 17	8. Date of Birth (Month, Day, Year) 07-17-44
	9. Birthplace (State or Foreign Country) MD				
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MD	10b. County NA	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 1631 Cliftview Avenue		10f. Zip Code 21213		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade College (1-4 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bar Tender		16b. Kind of Business/Industry P.P.P.
	17. Father's Name (First, Middle, Last) Thomas Bracey		18. Mother's Name (First, Middle, Maiden Surname) Bessie Stevenson		
	19a. Informant's Name/Relationship (Type, Print) Deborah T. Imode		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 1631 Cliftview Avenue Baltimore, Maryland		
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens		20c. Location - City or Town, State 11-13-2000 Dundalk, MD
	21. Signature of Funeral Service Licensee Bladys Wane		22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	a. pneumonia Due to (or as a consequence of):				two weeks
	b. gram negative bacteremia Due to (or as a consequence of):				three days
	c. human immunodeficiency virus Due to (or as a consequence of):				three years
	d.				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Dawn C. Hitchcock M.D.		29c. License number RES-000		29d. Date signed (Month, Day, Year) November 8, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dawn Hitchcock MD 600 North Wolfe Street Baltimore Maryland 21287					
State Registrar	31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature [Signature]		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35848

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Edna M. Smith</i>				2. Date of Death Month <i>Nov</i> Day <i>9</i> Year <i>2000</i>				3. Time of Death <i>800 pm</i>	
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical Systems</i>				4b. City, Town or Location of Death <i>Baltimore</i>				4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>218-22-2941</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>86</i> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth Month Day Year <i>Oct 16, 1914</i>		9. Birthplace (State or Foreign Country) <i>Delaware</i>		10a. State <i>MD</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Balto</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>730 Allendale</i>		10f. Zip Code <i>21229</i>		10g. Citizen of What Country? <i>U.S.A.</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10th</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>laborer</i>				16b. Kind of Business/Industry <i>Canning</i>	
	17. Father's Name (First, Middle, Last) <i>John Fisher</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Ethel Turner</i>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Lillian Scott daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>730 Allendale St. Balto. Md. 21229</i>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Cedar Hill Cem.</i>				20c. Location - City or Town, State <i>11/14/2000 Anne Arundel, Md.</i>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Carlton C. Douglas</i>				22. Name and Address of Facility <i>Carlton C. Douglas Funeral Service 1701 McCulloch St. Balto. Md. 21217</i>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Pulmonary edema</i> Due to (or as a consequence of):				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Aortic Stenosis</i> <i>Renal Failure</i>				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>13037</i>	
	29d. Date signed (Month, Day, Year) <i>November 10, 2000</i>									
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Arenda Rosenberg, MD 22 South Greene St., Baltimore, MD 21201</i>									
	31. Date filed (Month, Day, Year) <i>NOV 13 2000</i>				32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35849

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Leslie Scott</u>				2. Date of Death Month <u>November</u> Day <u>01</u> Year <u>2000</u>		3. Time of Death <u>10:30pm</u>	
	4a. Facility Name (If not institution, give street and number) <u>Mercy Medical Center</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>City</u>	
Funeral Director	5. Social Security Number <u>214-84-0722</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>38</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>Nov. 2, 1961</u>	9. Birthplace (State or Foreign Country) <u>Maryland</u>
	Usual Residence of Decedent				10a. State <u>Maryland</u>		10b. County <u>N/A</u>	
To Be Completed by Funeral Director	10c. City, Town or Location <u>Baltimore</u>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <u>402 Wickham Rd. Apt. E</u>	
	10f. Zip Code <u>21229</u>				10g. Citizen of What Country? <u>USA</u>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>2</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Asst. Teacher</u>		16b. Kind of Business/Industry <u>Good Shepherd Center</u>	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <u>Melvin B. Scott</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Pearl Dargan</u>			
	19a. Informant's Name/Relationship (Type, Print) (Sister) <u>Mrs. Barbara Whitehead</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2115 W. Saratoga St. Balto. Md. 21223</u>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Arbutus Mem. Park</u>		20c. Location - City or Town, State <u>Balto. Md.</u>		20d. Date <u>11/7/2000</u>	
	21. Signature of Funeral Service Licensee <u>Joseph L. Russ</u>		22. Name and Address of Facility <u>Joseph L. Russ Funeral Home</u> <u>2222 W. North Ave. Balto. Md. 21216</u>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <u>Massive Pulmonary Embolism</u> Due to (or as a consequence of): b. <u>Right Common Femoral Deep Vein Thrombosis 24 hours</u> Due to (or as a consequence of): c. <u>Right Femoral Vein Gunshot Wound</u> Due to (or as a consequence of): d. <u>Thrombotic Thrombocytopenic Purpura</u> Approximate Interval Between Onset and Death <u>8 days</u>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
Medical Certification: To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <u>Galen A. Kuznetsov, MD</u>				29c. License number <u>D40744</u>		29d. Date signed (Month, Day, Year) <u>November 11, 2000</u>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>K.A. Harzick</u> <u>Mercy Hospital</u> <u>301 St. Paul Pl, Baltimore</u>							
	31. Date filed (Month, Day, Year) <u>NOV 13 2000</u>				32. Registrar's Signature <u>[Signature]</u>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35850

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kimberly Ann Smith				2. Date of Death Month Day Year NOVEMBER 10, 2000		3. Time of Death 12:27 PM								
	4a. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL				4b. City, Town, or Location of Death COLUMBIA		4c. County of Death HOWARD								
Funeral Director	5. Social Security Number 212-76-9260		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 35 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 24 1965								
	10a. State MD.		10b. County Howard		10c. City, Town or Location Ellicott City		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Usual Residence of Decedent															
10e. Street and Number 3331 N. Chatham Road				10f. Zip Code 21043		10g. Citizen of What Country? U.S.A.									
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker		16b. Kind of Business/Industry own home									
17. Father's Name (First, Middle, Last) Barry E. Fee				18. Mother's Name (First, Middle, Maiden Surname) Donna Whitten											
19a. Informant's Name/Relationship (Type, Print) Brad MacFee, brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6278 Meadowcroft Rd., Eldersburg, Md. 21784											
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore/Washington Crem. 11/14/00		20c. Location - City or Town, State Laurel, Md.										
21. Signature of Funeral Service Licensee Thanda L Lemmer				22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave., Catonsville, Md. 21228											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. DILATED CARDIOMYOPATHY</td> <td rowspan="4">Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)	a. DILATED CARDIOMYOPATHY	Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b.	c.	d.
Immediate Cause (Final disease or condition resulting in death)	a. DILATED CARDIOMYOPATHY	Due to (or as a consequence of):	Approximate Interval Between Onset and Death												
	b.														
	c.														
	d.														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown															
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No															
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No															
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
			28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
29b. Signature and title of certifier J. Laron Locke, MD				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) NOVEMBER 11, 2000									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Laron Locke, MD 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) NOV 13 2000			32. Registrar's Signature J. Laron Locke												

Baltimore, Maryland 21215-0020

perm. l. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 23a,ptII, 27,28a,bc,d,ef,f per me G789 11/29/00

Certificate of Death

Reg. No.

00 35851

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
If the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HUN SUONG				2. Date of Death Month Day Year NOVEMBER 2, 2000				3. Time of Death 13:30 PM						
	4a. Facility Name (If not institution, give street and number) 9017 WALDON ROAD				4b. City, Town, or Location of Death SILVER SPRING				4c. County of Death MONTGOMERY						
Funeral Director	5. Social Security Number 216-04-8575		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 42 Yrs.		8. Date of Birth (Month, Day, Year) MAY 15, 1958		9. Birthplace (State or Foreign Country) CAMBODIA						
	Usual Residence of Decedent														
10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number 9017 WALDEN ROAD				10f. Zip Code 20901				10g. Citizen of What Country? CAMBODIAN							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: ASIAN						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CAMERAMAN				16b. Kind of Business/Industry TELEVISION							
17. Father's Name (First, Middle, Last) SOUNG GNEL				18. Mother's Name (First, Middle, Maiden Surname) ON SOUNG											
19a. Informant's Name/Relationship (Type, Print) MOEURN VONG / WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 EAST HAMILTON, SILVER SPRING, MARYLAND 20901											
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE WASHINGTON CR		Date 11/6/00		20c. Location - City or Town, State LAUREL, MARYLAND									
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. SMOKE INHALATION AND THERMAL INJURIES Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
										24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE											
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending 2 <input type="checkbox"/> Accident investigation 3 <input type="checkbox"/> Suicide 6 <input checked="" type="checkbox"/> Could not be 4 <input type="checkbox"/> Homicide determined		28a. Date of Injury (Month, Day, Year) 11/2/00		28b. Time of Injury 12:47 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred house fire							
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence				28f. Location (Street and Number or Rural Route Number, City or Town, State) 9017 Waldon Road, Silver Spring, Montgomery County, Maryland							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) NOVEMBER 3, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 													

10074

1117

10074

10074

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35852

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Meredith Billingsley Sweet

2. Date of Death

Month Day Year
November 03, 2000

3. Time of Death

7:38 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

14450 Jasmine Court

4b. City, Town, or Location of Death

Issue

4c. County of Death

Charles

5. Social Security Number

459-66-1015

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec 23 1936

9. Birthplace (State or Foreign Country)

USA, Calif

Usual Residence of Decedent

10a. State

MD

10b. County

Charles Co.

10c. City, Town or Location

Issue

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

14450 Jasmine St.

10f. Zip Code

20645

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates: 195913. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2+

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Claude Augustus Billingsley

18. Mother's Name (First, Middle, Maiden Surname)

Mary Dee Osborne

19a. Informant's Name/Relationship (Type, Print)

Mary Gretchen Johnson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

41861 Raspberry Drive Leesburg, VA 20176

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arlington National Cem 11/08/00 Arlington

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Everly-Wheatley Funeral Home

1500 W Braddock Rd. Alex. VA 22302

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Hypertensive Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LIVER CIRRHOSIS

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☒ Yes ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?☒ Yes ☐ No25. Was case referred to medical
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☒ Other (Specify) at scene

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

November 04, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACK M. TINS, M.D.

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

J. M. Tins

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
20253.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35853

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

WILLIE MAE SMITH

2. Date of Death

November 6, 2000

3. Time of Death

11:36 a.m.

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

217-24-5304

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 10 1928

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State
MARYLAND10b. County
N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3305 DORCHESTER RD

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12yrs

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SCHOOL TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

WALTER SMITH

18. Mother's Name (First, Middle, Maiden Surname)

INEZ CARTER SMITH

19a. Informant's Name/Relationship (Type, Print)

Eris L. Smith/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3305 Dorchester Rd., Baltimore, Maryland 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

20c. Location - City or Town, State

11-11-00 BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WILLIAM C BROWN COMMUNITY FUNERAL HOME PA
1206 W NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Carcinoma

Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ledy Valle MD

29c. License number

P14288

29d. Date signed (Month, Day, Year)

November 7, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ledy Valle MD 2401 West Belvedere Baltimore, MD 21215

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Patient known as: Willie Mae Smith

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35854

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES ALBERT STRICKLAND

2. Date of Death

Month Day Year
OCTOBER 21, 2000

3. Time of Death

2:30 PM

4a. Facility Name (If not institution, give street and number)

3870 Ponder Drive

4b. City, Town, or Location of Death

Edgewater

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

214-38-5388

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 24, 1922

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Edgewater

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3870 Ponder Drive

10f. Zip Code

21037

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

unk

College (1-4 or 5+)

unk

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

unk

16b. Kind of Business/Industry

U.S. Marines

17. Father's Name (First, Middle, Last)

Albert C. Strickland

18. Mother's Name (First, Middle, Maiden Surname)

Jacqueline A. Wallace

19a. Informant's Name/Relationship (Type, Print)

unk

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unk

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PARKINSONS DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. 1

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

10 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BLADDER CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Peter R. Grange MD

29c. License number

DL6364

29d. Date signed (Month, Day, Year)

11/7/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETER GRANGE 900 BESTGATE RD/STE 300 ANNAPOLIS, MD

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35855

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THOMAS STUMMER			2. Date of Death Month Day Year NOVEMBER 5, 2000			3. Time of Death 5:41 AM								
	4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER			4b. City, Town, or Location of Death BALTIMORE			4c. County of Death								
Funeral Director	5. Social Security Number 219-38-9743		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Apr 25, 1943		9. Birthplace (State or Foreign Country) unk		
	Usual Residence of Decedent														
10a. State MD		10b. County		10c. City, Town or Location Baltimore						10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 1213 Light Street						10f. Zip Code 21230				10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No unk If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4 or 5+) unk						16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) disabled						16b. Kind of Business/Industry none			
17. Father's Name (First, Middle, Last) unk						18. Mother's Name (First, Middle, Maiden Surname) unk									
19a. Informant's Name/Relationship (Type, Print) unk						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk									
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state						20b. Place of Disposition (Name of cemetery, crematory or other place)				Date		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee Ronald S. Wade, Director						22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201									
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)														1 DAY	
a. RESPIRATORY FAILURE Due to (or as a consequence of):														1-2 DAYS	
b. PNEUMONIA Due to (or as a consequence of):														10 YEARS	
c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of):															
d.															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPONATREMIA														23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined						28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier Ronald S. Wade						29c. License number RES000		29d. Date signed (Month, Day, Year) NOVEMBER 5, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARBOR HOSPITAL CENTER 3001 SOUTH HANOVER STREET, BALTIMORE, MD															
31. Date filed (Month, Day, Year) NOV 13 2000						32. Registrar's Signature [Signature] 21225									

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35856

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JUDITH STIFFMAN

2. Date of Death

Month Day Year
NOVEMBER 2 2000

3. Time of Death

7:20 AM

4a. Facility Name (If not institution, give street and number)

Wilson Health Care

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

579-09-2771

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct 23, 1915

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

301 Russell Avenue

10f. Zip Code

20877

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

housewife

16b. Kind of Business/Industry

none

17. Father's Name (First, Middle, Last)

Israel Kurland

18. Mother's Name (First, Middle, Maiden Surname)

Lena Becker

19a. Informant's Name/Relationship (Type, Print)

M. Alexander Stiffman/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8511 Rosewood Drive Bethesda, MD 20814

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

LUNG CARCINOMA

Approximate Interval Between Onset and Death

1 YEAR

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31563

29d. Date signed (Month, Day, Year)

NOVEMBER 3, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES M. BEWER, MD 11251 LOCKWOOD DRIVE, SILVER SPRING, MD 20901

State
Registrar

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

Bewer Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35857
Certificate of Death

Reg. No.

Patient Known as Rachel Steinberg

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RACHEL STEINBERG				2. Date of Death Month Day Year November 6, 2000		3. Time of Death 3:35 AM
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A
Funeral Director	5. Social Security Number 543-80-0545	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 41 Yrs.	8. Date of Birth (Month, Day, Year) FEB 26, 1959	9. Birthplace (State or Foreign Country) CALIFORNIA		
	Usual Residence of Decedent				10. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location OWINGS MILLS		10d. Inside City Limits	
10e. Street and Number 5 TAHOE CIRCLE				10f. Zip Code 21117		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WAITRESS		16b. Kind of Business/Industry FOOD	
17. Father's Name (First, Middle, Last) LEONARD REYES				18. Mother's Name (First, Middle, Maiden Surname) LYDIA GARCIA			
19a. Informant's Name/Relationship (Type, Print) STUART STEINBERG (HUS.)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 TAHOE CIR. OWINGS MILLS, MD 21117			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MOSES MONTEFIORE WOODMOOR HEBREW		20c. Location - City or Town, State BALTO., MD		20d. Date 11/9/00	
21. Signature of Funeral Service Licensee <i>Bolet</i>				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Sepsis Due to (or as a consequence of): b. Liver Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 48 hours 3 weeks
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hepatitis C, Alcoholism, Ascites Tobacco Abuse							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Steven Hamlette, M.D.</i>		29c. License number RES000		29d. Date signed (Month, Day, Year) November 6, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Hamlette, M.D. Sinai Hospital of Baltimore							
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature <i>Bernice B. Spotts</i>					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35858

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SAMUEL THOMPSON		2. Date of Death Month NOVEMBER Day 5 Year 2000		3. Time of Death 22:37
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore City		4c. County of Death NA
Funeral Director	5. Social Security Number 220-64-5521	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 43 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 10-28-57		9. Birthplace (State or Foreign Country) MD		
Usual Residence of Decedent					
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
10e. Street and Number 2210 East Fayette Street		10f. Zip Code 21231		10g. Citizen of What Country? USA	
11. Mental Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Moving		16b. Kind of Business/Industry Mayflower Moving Co.	
17. Father's Name (First, Middle, Last) James S. Thompson			18. Mother's Name (First, Middle, Maiden Surname) Fannie M. Williams		
19a. Informant's Name/Relationship (Type, Print) Fannie Rogers			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2210 E. Fayette Street Baltimore, Maryland 21231		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery 11-11-2000		20c. Location - City or Town, State Lansdowne, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E.North Avenue			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. NECROTIZING FASCIITIS Due to (or as a consequence of):			Approximate Interval Between Onset and Death ONE DAY
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. INTRAVENOUS DRUG USE Due to (or as a consequence of):			ONE WEEK
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number RES-000		29d. Date signed (Month, Day, Year) NOVEMBER 5, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EMILY WHITE 600 NORTH WOLFE STREET BALTIMORE MD 21287-9106					
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35859

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN W. THOMPSON				2. Date of Death Month: NOVEMBER Day: 11th Year: 2000		3. Time of Death 01:45		
	4a. Facility Name (If not institution, give street and number) Levindale Hebrew Center and Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 215-12-9814	6. Sex XX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months: Days: Hours: Min.	8. Date of Birth (Month, Day, Year) Aug. 19, 1922	9. Birthplace (State or Foreign Country) Delaware			
	Usual Residence of Decedent								
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Timonium		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 223 Burning Tree Road				10f. Zip Code 21093		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Optical Engineer		16b. Kind of Business/Industry Defense			
17. Father's Name (First, Middle, Last) John T. Thompson				18. Mother's Name (First, Middle, Maiden Surname) Thelma E. Richardson					
19a. Informant's Name/Relationship (Type, Print) John W. Thompson, Jr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7890 Hampton Village Pass Annadale, Virginia 22003					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial		Date 11/15/00		20c. Location - City or Town, State Timonium, Maryland			
21. Signature of Funeral Service Licensee Lynn B. Henss				22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road, Timonium, Maryland 21093					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CORONARY ARTERY DISEASE Due to (or as a consequence of): b. EMPHYSEMA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 5 YEARS 5 YEARS									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Dona M. Cuenley M.D.				29c. License number D54739		29d. Date signed (Month, Day, Year) NOVEMBER 11th 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W Belvedere Avenue, Baltimore Maryland 21215									
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature [Signature]							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35860

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Bernadine C Turner</i>				2. Date of Death Month <i>November</i> Day <i>8</i> Year <i>2000</i>				3. Time of Death <i>8:21 AM</i>			
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical System</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>NIA</i>			
Funeral Director	5. Social Security Number <i>215-12-9386</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>77</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>MARCH 28, 1923</i>		9. Birthplace (State or Foreign Country) <i>MARYLAND</i>			
	Usual Residence of Decedent				10a. State <i>MARYLAND</i>				10b. County <i>N/A</i>			
10c. City, Town or Location <i>BALTIMORE CITY</i>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
10e. Street and Number <i>2426 W. BALTIMORE ST.</i>				10f. Zip Code <i>21223</i>				10g. Citizen of What Country? <i>U.S.A.</i>				
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				
14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12TH GRADE</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>COOK</i>				
16b. Kind of Business/Industry <i>FOOD SERVICE</i>				17. Father's Name (First, Middle, Last) <i>UNKNOWN</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>MARGARET WARFIELD</i>				
19a. Informant's Name/Relationship (Type, Print) <i>GENEVA DAVIS (DAUGHTER)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2105 BOYD ST., BALTIMORE, MD 21223</i>								
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>WESTERN STAR CEMETERY</i>				20c. Location - City or Town, State <i>11-13-2000 CATONSVILLE, MARYLAND</i>				
21. Signature of Funeral Service Licentiate <i>[Signature]</i>				22. Name and Address of Facility <i>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD 21217</i>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Myocardial Infarction</i> Due to (or as a consequence of): b. <i>Coronary Artery disease</i> Due to (or as a consequence of): c. <i>Hypertension</i> Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) <i>M</i>				28b. Time of Injury <i>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</i>				
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>D0043742</i>				
29d. Date signed (Month, Day, Year) <i>November 8, 2000</i>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Brian Euerke, MD 22 South Greene St., Baltimore, Maryland 21201</i>								
31. Date filed (Month, Day, Year) <i>NOV 13 2000</i>				32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35861

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

David Taylor

2. Date of Death

November 9 2000

3. Time of Death

4:05 AM

4a. Facility Name (If not institution, give street and number)

Baltimore V. A Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

226 12 8213

6. Sex

M 20 F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 29, 1921

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

BALTIMORE

10c. City, Town or Location

LOCHARN

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

3927 Southern Cross Drive

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Heavy Duty Crane Operator

16b. Kind of Business/Industry

Spartan Point Steel Company

17. Father's Name (First, Middle, Last)

Samuel Taylor

18. Mother's Name (First, Middle, Maiden Surname)

Polly Scruggs

19a. Informant's Name/Relationship (Type, Print)

EMMA D. TAYLOR / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3927 Southern Cross Drive Baltimore, Maryland 21207

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHELTENHAM Veterans Cemetery

Date

11-16-2000

20c. Location - City or Town, State

CHELTENHAM, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

CHATHAM - HARRIS Funeral Home
5240 REISTERSTOWN ROAD
BALTIMORE, Maryland 21115

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. septic shock

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ischemic bowel

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jima Jank, MD

29c. License number

P14691

29d. Date signed (Month, Day, Year)

November 9, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jima Jank, MD BVAMC 10 N. Greene St. Baltimore, MD 21201

State
Registrar

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35862

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LOTTIE WEBB

2. Date of Death
Month Day Year

NOVEMBER 3, 2000

3. Time of Death

6:30pm

4a. Facility Name (If not institution, give street and number)

MILLENNIUM OF FRANKLIN SQUARE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral
Director

5. Social Security Number

218-70-7457

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

DEC. 7, 1907

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1217 W. FAYETTE STREET

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: AFRICAN

AMERICAN

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

PETER ECKLES

18. Mother's Name (First, Middle, Maiden Surname)

JANIE ECKLES

19a. Informant's Name/Relationship (Type, Print)

YOLANDA D. THOMAS (GUARDIAN)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5205 IVANHOE AVENUE BALTIMORE, MD 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEMETERY

Date

11/11/00 LANSDOWNE, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WYLIE FUNERAL HOME PA

638 N. GILMOR STREET BALTIMORE, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Aspiration pneumonia

Due to (or as a consequence of):

1 wk

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

10 years +

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M. O. K. King, MD

29c. License number

D 31865

29d. Date signed (Month, Day, Year)

11-6-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rm 206

821 N. Gilmor street, Baltimore, Md 21201

State
Registrar

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35863

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ernestine Fraction Wilson

2. Date of Death

November 7, 2000 2:13 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral
Director

5. Social Security Number

213-26-9705

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

09 28 28

9. Birthplace (State or Foreign Country)

M.D.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2521 Edmondson Ave

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (14 or 5+)

12th grade na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Crossing Guard

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

Willie Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Pearl P. Stewart

19a. Informant's Name/Relationship (Type, Print)

Joseph Fraction-Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

516 Normandy Ave, Baltimore Md 21229

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Park 11/13/00 Arbutus, Md

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Diabetes Mellitus, Coronary

Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

P13520

29d. Date signed (Month, Day, Year)

11/7/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Adams, M.D. c/o Maryland General Hospital

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 303A.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Ernestine Wilson

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35864

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

CLIFTON WALKER

2. Date of Death
Month Day Year
NOVEMBER 12, 20003. Time of Death
8:28am

4a. Facility Name (If not institution, give street and number)

HARBORSIDE NURSING CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

5. Social Security Number

579-24-2275

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
DEC. 23, 1904

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4700 HARFORD ROAD

10f. Zip Code

21214

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:
AFRICAN
AMERICAN15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5) unk

12th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

LIBRARIAN

16b. Kind of Business/Industry

US TREASURY

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

ALICE BELLAMY (GURADIAN)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

34 MARKET PLACE SUITE 300 BALTIMORE, MD 21202

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MT. ZION CEMETERY

Date

11/17/00

20c. Location - City or Town, State

LANSDOWNE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WYLIE FUNERAL HOME PA

638 N. GILMOR STREET BALTIMORE, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Colon cancer

Due to (or as a consequence of):

b. Gastrointestinal bleed

Due to (or as a consequence of):

c. Peripheral vascular disease

Due to (or as a consequence of):

d. Syncope

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHARIS A. HASHMI, 821 N. EUTAW ST Suite 308, Balt MD 21201

State
Registrar

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

Brenda G. Sparks

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 35865

AMEND#17&18 #19A PER F.H. G789 11-13-2000 JAB

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) YORKIE WASHINGTON				2. Date of Death Month NOVEMBER Day 2 Year 2000		3. Time of Death 6:15 PM	
	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL				4b. City, Town, or Location of Death RANDALLSTOWN		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 197-07-0285		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) MAY 2, 1912	
	9. Birthplace (State or Foreign Country) VA		10a. State MD		10b. County NA		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 607 ACADEMY ROAD		10f. Zip Code 21228		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry STEEL				
17. Father's Name (First, Middle, Last) HARMAN WASHINGTON SR.				18. Mother's Name (First, Middle, Maiden Surname) PEARLY WASHINGTON				
19a. Informant's Name/Relationship (Type, Print) YVONNE M. WASHINGTON - DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 ACADEMY ROAD BALTIMORE, MD 21228				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK		20c. Location - City or Town, State 11/8/00 RANDALLSTOWN, MD				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate CA, OGS, MRSN								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D44505		29d. Date signed (Month, Day, Year) November 2, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A.J. IMPERIAL, JR., MD - D44505								
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible..

State of Maryland / Department of Health and Mental Hygiene

00 35866

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thelbert Wayne White				2. Date of Death Month November Day 10 , Year 2000		3. Time of Death 1936 pm	
	4a. Facility Name (If not institution, give street and number) Bons Secours Hospital.				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 224-74-6912	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 10-2-50		9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County NA	10c. City, Town or Location Baltimore, Maryland			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 825 Wedgewood Rd.			10f. Zip Code 21229		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (14 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Inner City Towing			
17. Father's Name (First, Middle, Last) Norman White				18. Mother's Name (First, Middle, Maiden Surname) Laurabelle Dotson				
19a. Informant's Name/Relationship (Type, Print) Addie White				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 825 Wedgewood Rd. Baltimore, MD 21229				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Luke's Baptist Church Cemetery		20c. Location - City or Town, State 11/17/00 Skipwith, Virginia		
21. Signature of Funeral Service Licensee L. Valencia Holland				22. Name and Address of Facility Wm. C. March F/H 1101 E. North Ave. Baltimore, MD 21202				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner				29b. Signature and title of certifier J. Aaron Locke, MD				
				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) November 11, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature James B. Sparks				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

1950

1951

1952

1953

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

00 35867

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Addison Welch				2. Date of Death Month Day Year November 10, 2000		3. Time of Death 7:34 P.M.			
	4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center			4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A				
Funeral Director	5. Social Security Number 214-03-0766	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 18, 1914	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD	10b. County Caroline	10c. City, Town or Location Denton		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number 25766 Beauchamp Branch Road			10f. Zip Code 21629		10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Oil Burner Technician		16b. Kind of Business/Industry Enterprise Fuel			
	17. Father's Name (First, Middle, Last) James Benjamin Welch				18. Mother's Name (First, Middle, Maiden Surname) Addie Beauchamp					
	19a. Informant's Name/Relationship (Type, Print) D. Shirlyn Clark - Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2312 Susanann Drive; Hampstead, MD 21074						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park		Data 11/13/00		20c. Location - City or Town, State Baltimore, MD			
	21. Signature of Funeral Service Licensee Joseph Kellner		22. Name and Address of Facility Loring Byers Funeral Directors Inc. 8728 Liberty Road; Randallstown, MD 21133							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. C-2 Fracture with Complications Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last { }								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? Approval <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 11-02-2000		28b. Time of Injury 8:30 PM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
		28d. Date of Injury (Month, Day, Year) 11-02-2000		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Vacant House		28f. Describe how injury occurred Subject fell on head while attempting to shut off water main to house.				
		28g. Location (Street and Number or Rural Route Number, City or Town, State) 25210 Beauchamp Branch Road, Denton, Maryland								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Assistant Professor		29c. License number D-0047971		29d. Date signed (Month, Day, Year) November 11, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maureen McCunn, M.D. 22 South Greene Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature Benjamin B Sparks								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35868

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jeannette E. Warfield				2. Date of Death Month November Day 10 Year 2000		3. Time of Death 8:02 am	
	4a. Facility Name (If not institution, give street and number) Stella Maris				4b. City, Town, or Location of Death Timonium		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 220-09-3848		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 23, 1921	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Timonium	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 2300 Dulaney Valley Road			
	10f. Zip Code 21093				10g. Citizen of What Country? USA			
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Year or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Manager		16b. Kind of Business/Industry Beverage			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Alfred Witter				18. Mother's Name (First, Middle, Maiden Surname) Jeannette Henneman			
	19e. Informant's Name/Relationship (Type, Print) Alfred Warfield/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 816 Ruxshire Drive Arnold, MD 21012			
To Be Completed by Physician/Medical Examiner	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Redeemer Cemetery		Date Nov. 14 2000		20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Director 		22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Chronic heart failure						Approximate Interval Between Onset and Death years	
	Due to (or as a consequence of): Hypertension						years	
To Be Completed by Physician/Medical Examiner	Due to (or as a consequence of): Generalized arteriosclerosis						years	
	Due to (or as a consequence of):							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Enlarged heart failure Chronic lung disease						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and Title of Certifier 	
	29c. License number D 15504		29d. Date signed (Month, Day, Year) 11. 10. 00					
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093							
	31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35869

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Ralph Whetstone				2. Date of Death Month Day Year NOVEMBER 9 2000				3. Time of Death 7:18 A.M.		
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER				4b. City, Town, or Location of Death ROSEDALE				4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 216-40-2902		6. Sex M 2 F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 12, 1942		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex				10d. Inside City Limits 1 Yes 2 No			
10e. Street and Number 1804 Kitty Hawk Road				10f. Zip Code 21221				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steel Worker				16b. Kind of Business/Industry Steel Mill			
17. Father's Name (First, Middle, Last) George Mays Whetstone				18. Mother's Name (First, Middle, Maiden Surname) Margaret LuCretia Skelly							
19a. Informant's Name/Relationship (Type, Print) Thelma Louise Whetstone				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1804 Kitty Hawk Road, Essex, Maryland 21221							
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GreenMount Crematory				20c. Location - City or Town, State 11/13/2000 Baltimore, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Brudzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221				Approximate Interval Between Onset and Death 24 Hours			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS PERIPHERAL VASCULAR DISEASE											
25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number D36663		29d. Date signed (Month, Day, Year) NOVEMBER 9, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STUART R. WILLES, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237											
31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature 							

WHETSTONE, JOSEPH

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35870

AMEND ITEM 8 PER F.H. G789 11-21-00 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Florence Alma Woolfenden				2. Date of Death Month Day Year November 11, 2000				3. Time of Death 10:15AM			
	4a. Facility Name (If not institution, give street and number) Mariner Health of Overlea				4b. City, Town, or Location of Death Overlea				4c. County of Death Baltimore City			
Funeral Director	5. Social Security Number 216-12-5814		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) 1922 March 21, 1924		9. Birthplace (State or Foreign Country) Massachusetts			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 10 Cottage Avenue				10f. Zip Code 21222		10g. Citizen of What Country? U.S.A.					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse-RN			16b. Kind of Business/Industry Hospital				
	17. Father's Name (First, Middle, Last) William A. Harrison				18. Mother's Name (First, Middle, Maiden Surname) Ethel Hill							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Theresa Hershey (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9A Mopec Circle, Baltimore, Maryland 21236							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest V.A. Cem.		20c. Date Nov. 16, 2000		20d. Location - City or Town, State Owings Mill, Maryland					
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Bruzdinski Funeral Home P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. CORONARY ARTERY DIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 1 HR	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	29b. Signature and title of certifier		29c. License number D08344		29d. Date signed (Month, Day, Year) 11/13/00							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Rivera, M.D., 5714 Harford Road, Baltimore, Maryland 21214												
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature B Spauls										

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35871

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth B. Widmeyer

2. Date of Death

Month Day Year
November 7 2000 2 55 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Homewood at Williamsport

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

Washington

5. Social Security Number

214-46-5104

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
October 27, 1913

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Williamsport

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

16505 Virginia Avenue

10f. Zip Code

21795

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Albert Botsford

18. Mother's Name (First, Middle, Maiden Surname)

Edna Sutor

19a. Informant's Name/Relationship (Type, Print)

John H. Widmeyer, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13212 Glendale Drive Hagerstown, MD 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hancock Presbyterian

Date

11/13/00

20c. Location - City or Town, State

Hancock, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Grove Funeral Home, P.A.

141 West Main Street Hancock, MD 21750-0368

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. *Arteriosclerotic cardiovascular disease months*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Abnormal pressure hydrocephalus

Dementia

Osteoporosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 26806

29d. Date signed (Month, Day, Year)

November 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AND. H. MD. 747 Northon Ave Hagerstown MD 21742

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

[Signature]

State
Registrar

11-7-00 2:55 pm
Baltimore, Maryland 21215-0020

Ruth Widmeyer
Division of Vital Records, P.O. Box 68760,

24
YF

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35872

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David Walker				2. Date of Death Month Day Year November 08, 2000		3. Time of Death 10:46 A.M.	
	4a. Facility Name (If not institution, give street and number) 110 North Central Avenue, Apartment 307				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 230-22-8530		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) 03/11/1925	
	9. Birthplace (State or Foreign Country) Virginia		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 110 North Cetral Ave, Apt. 307		10f. Zip Code 21202		
10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steel worker		16b. Kind of Business/Industry Bethlehem Steel		
17. Father's Name (First, Middle, Last) Graham Walker				18. Mother's Name (First, Middle, Maiden Surname) Blanche Taylor				
19a. Informant's Name/Relationship (Type, Print) Edna Mae Walker				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 N. Gilmor Street, Baltimore, MD 21223				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery 11/13/00		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee Willie E Howell				22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HEIGHTS AVE., BALTO., MD 21207				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. Was an autopsy performed? Inspection <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				
28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier Stephen Radentz, M.D.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) November 09, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) NOV 13 2000				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35873

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Lue Wood		2. Date of Death Month November Day 10 Year 2000		3. Time of Death 4:55 PM
	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice at Mercy		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 217-26-2507	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) December 25, 1920		9. Birthplace (State or Foreign Country) Virginia		
Usual Residence of Decedent					
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 412 S. Durham Street			10f. Zip Code 21231		10g. Citizen of What Country? United States
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress		16b. Kind of Business/Industry Restaurant	
17. Father's Name (First, Middle, Last) Emmett Marion Montgomery			18. Mother's Name (First, Middle, Maiden Surname) Lula May Fuller		
19a. Informant's Name/Relationship (Type, Print) Violet M. Keiter/Niece			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1301 Walker Rd. Freeland, Maryland 21053		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oaklawn Cemetery		20c. Location - City or Town, State 11/14 Baltimore Maryland	
21. Signature of Funeral Service Licensee Kathleen Weber, CFSP		22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester St. Baltimore Maryland 21231			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) STELLA MARIS AT MERCY HOSPICE					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier Dr. [Signature]		29c. License number D40854		29d. Date signed (Month, Day, Year) NOVEMBER 10, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID RISEBERG 301 ST PAUL PI, BALTIMORE MD 21202					
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature [Signature]			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35874

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Ida A. York</i>		2. Date of Death Month <i>November</i> Day <i>7</i> Year <i>2000</i>		3. Time of Death <i>11:05 pm</i>	
	4a. Facility Name (If not institution, give street and number) <i>Mercy Medical Center</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>NA</i>	
Funeral Director	5. Social Security Number <i>219-38-2556</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>65</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <i>05-02-35</i>		9. Birthplace (State or Foreign Country) <i>NC</i>			
Usual Residence of Decedent						
10a. State <i>MD</i>		10b. County <i>NA</i>		10c. City, Town or Location <i>Baltimore</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <i>931 Valley Street</i>			10f. Zip Code <i>21202</i>		10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11th Grade</i> College (1-4 or 5+) <i>NA</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Day Care Provider</i>		16b. Kind of Business/Industry <i>in home</i>	
17. Father's Name (First, Middle, Last) <i>Clifton Leggett</i>			16. Mother's Name (First, Middle, Maiden Surname) <i>Ethel Leggett</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Zina Garrett</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>21206</i> <i>5006 Barton Avenue Baltimore, Maryland</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>King Mem. Pk. Cem.</i>		20c. Location - City or Town, State <i>11-11-2000 Randallstown, MD</i>	
21. Signature of Funeral Service Licensee <i>Bladys Wane</i>			22. Name and Address of Facility <i>Baltimore, Maryland 21202</i> <i>WM.C. March FH 1101 E. North Avenue</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
Immediate Cause (Final disease or condition resulting in death)						
Severely Sepsis						
Due to (or as a consequence of):						
Bacterial pneumonia						
Due to (or as a consequence of):						
Due to (or as a consequence of):						
Due to (or as a consequence of):						
Approximate Interval Between Onset and Death <i>days</i> <i>days</i>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>acute renal failure, metabolic Acidosis, hyperkalemia</i>						
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>	
			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier <i>Wm Todd</i>			29c. License number <i>D 37790</i>		29d. Date signed (Month, Day, Year) <i>November 8, 2000</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Norris W Todd 301 St Paul Place Baltimore MD 21202</i>						
31. Date filed (Month, Day, Year) <i>NOV 13 2000</i>			32. Registrar's Signature <i>B Sparks</i>			

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit data.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35875

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Albert Lee Ames				2. Date of Death Month October Day 27 Year 2000		3. Time of Death 01 24	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 213-22-6940		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) 1-1-27	
	9. Birthplace (State or Foreign Country) VA		10a. State MD		10b. County Worcester		10c. City, Town or Location Pocomoke City	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1542 Unionville Road		10f. Zip Code 21851		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 6/11/45 - 11/22/46		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (9-12) 9th grade College (1-4 or 5+) Truck - driver		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Perdue Farms		16b. Kind of Business/Industry Perdue Farms		17. Father's Name (First, Middle, Last) Samuel Ames	
	18. Mother's Name (First, Middle, Maiden Surname) Mamie Gaskin		19a. Informant's Name/Relationship (Type, Print) Burnette Ames		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1542 Unionville Rd Pocomoke MD 21851		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) mt. Zion U.M.C.		20c. Location - City or Town, State 11/4/00 Pocomoke City, MD		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility BENNIE SMITH FUNERAL HOME P.O. BOX 331 POCOMOKE CITY, MARYLAND 21851	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Respiratory Failure.		Due to (or as a consequence of): Chronic obstructive pulmonary disease.		Due to (or as a consequence of): pneumonia.		Due to (or as a consequence of):	
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 10/27/00		28b. Time of Injury M	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D31546		29d. Date signed (Month, Day, Year) 10/27/00	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. C. D. Nardo M.D. 136 MILFORD ST. SALISBURY, MD 21804		31. Date filed (Month, Day, Year) OCT 31 2000		32. Registrar's Signature 		33. Date of Death 10/27/00	

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35876

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JERALD ANDERSON				2. Date of Death Month Day Year OCTOBER 20 2000		3. Time of Death 2024		
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death n/a		
Funeral Director	5. Social Security Number 477-48-5282		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		9. Birthplace (State or Foreign Country) Washington		
	10a. State Maryland		10b. County Carroll		10c. City, Town or Location Westminster		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 485 Pleasonton Road #31		10f. Zip Code 21157		10g. Citizen of What Country? United States					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Vietnam		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Worker		16b. Kind of Business/Industry State Hospital					
17. Father's Name (First, Middle, Last) Berger A. Anderson, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Jeanette A. Morken					
19a. Informant's Name/Relationship (Type, Print) Dr. Wayne B. Anderson / Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1028 Wintergreen Terrace Rockville, Md. 20850					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory		20c. Date 10/23/00		20d. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Schumnek Funeral Home, Inc. 9705 Belair Road Baltimore, Maryland 21236							
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (List on each line.) Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Dua to (or as a consequence of): b. ACUTE MYELOGENOUS LEUKEMIA Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ACUTE RENAL FAILURE ACUTE MYOCARDIAL INFARCTION								Approximate Interval Between Onset and Death 1 week 3 months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE RENAL FAILURE ACUTE MYOCARDIAL INFARCTION								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  MD		29c. License number RES-000		29d. Date signed (Month, Day, Year) OCTOBER 20, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC D. JACOBSEN MD, TOWER 110, JOHNS HOPKINS, 600 NORTH WOLFE STREET BALTIMORE 21205									
31. Date filed (Month, Day, Year) OCT 24 2000		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35877

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harry John Bullerin

2. Date of Death

Month Day Year
October 23, 2000

3. Time of Death

0312

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

057-44-0776

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Mar. 31, 1952

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

130 S. Rogers Street

10f. Zip Code

21001

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

1973

1978

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: Puerto Rican

14. Race - American Indian, Black, White, etc.

Specify: Puerto Rican

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Driver

16b. Kind of Business/Industry

Auto Wholesale

17. Father's Name (First, Middle, Last)

(unknown) (unknown) (unknown)

18. Mother's Name (First, Middle, Maiden Surname)

Eladia (unknown) (unknown)

19a. Informant's Name/Relationship (Type, Print)

Teresa L. Bullerin/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

130 S. Rogers Street, Aberdeen, MD 21001

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

10/26/00 Towson, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Steph A. Murphy

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, MD 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE COR PULMONALE

Due to (or as a consequence of):

b. THROMBOSIS, RIGHT ATRIUM

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

C.H.F

CHRONIC RENAL FAILURE

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was cause related to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ramiro Lindado MD - Pathologist

29c. License number

D0015466

29d. Date signed (Month, Day, Year)

10-23-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAMIRO R LINDADO, MD

3205 Rolling Green Dr - Churchville, MD

State
Registrar

31. Date filed (Month, Day, Year)

OCT 26 2000

32. Registrar's Signature

[Signature]

21028

1000 3 3 130

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35878

Amend Item#1, 24b, 26HCHD BRH

Certificate of Death 10-26-00 Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Joyce S. Brooks

JOYCE ALICE BROOKS

2. Date of Death

Month

Day

Year

10

23

2000

3. Time of Death

9:15a

4a. Facility Name (If not institution, give street and number)

Brightview Assisted Living

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

160-20-2308

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 14, 1926

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Kingsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12420 Jerusalem Road

10f. Zip Code

21087

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph (u/k) Sodie

18. Mother's Name (First, Middle, Maiden Surname)

Alice Elaine Worry

19a. Informant's Name/Relationship (Type, Print)

Jeffrey Brooks/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

224B Timber Trail, Bel Air, MD 21014

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

10-24-00

20c. Location - City or Town, State

Towson, MD

21. Signature of Funeral Service Representative

David S. Dunn

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, MD 21009

23a. Permit. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. chronic obstructive pulmonary disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 Td

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Living

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

David S. Dunn

29c. License number

032277

29d. Date signed (Month, Day, Year)

October 23, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David S. Dunn 615 W. MacPhail

31. Date filed (Month, Day, Year)

OCT 26 2000

32. Registrar's Signature

David S. Dunn

State Registrar

Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-3000.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35879

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Vivian S. Brown

2. Date of Death

Month Day Year
November 3 2000

3. Time of Death

5:25 P.

4a. Facility Name (If not institution, give street and number)

Calvert Manor Health Care Center Rising Sun MD Cecil Co.

4b. City, Town, or Location of Death

4c. County of Death

Cecil Co.

5. Social Security Number

160-36-7267

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 4 1909

9. Birthplace (State or Foreign Country)

Little Britain Twp PA

Usual Residence of Decedent

10a. State
PA

10b. County

Chester

10c. City, Town or Location

Oxford PA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

208 Roneys Corner Rd.

10f. Zip Code

19363

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

home maker

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Howard R. Cook

18. Mother's Name (First, Middle, Maiden Surname)

Mary J. Scotten

19a. Informant's Name/Relationship (Type, Print)

Everett B. Cook

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

208 Roneys Corner Rd, Rising Sun MD 19363

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Little Britain Presby Ceme

Date

November 3, 2000

20c. Location - City or Town, State

Little Britain PA

21. Signature of Funeral Service Licensee

John Reynolds

22. Name and Address of Facility

Reynolds Funeral Home 144 E State St.
Perryville PA 17564

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Coronary Artery Disease

Due to (or as a consequence of):

b. ASCVD

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

2 yrs.
2 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Neil R Taylor MD

29c. License number

D-11115

29d. Date signed (Month, Day, Year)

11-03-00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Neil R Taylor Jr MD PO 459, Rising Sun, MD

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

Benjamin A Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35880

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Martha Stapleton Bodycombe

2. Date of Death
Month Day Year

October 22, 2000

3. Time of Death

3:00pm

4a. Facility Name (If not institution, give street and number)

Citizens Nursing Home

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

336-52-5517

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 25, 1911

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

415 S. Market Street

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Chalmers (NMN) Stapleton

18. Mother's Name (First, Middle, Maiden Surname)

Geraldine (NMN) Troutman

19a. Informant's Name/Relationship (Type, Print)

Daughter
Gwyneth Bodycombe Howard/

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2400 Castleton Road, Darlington, MD 21034

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service, Corp.

Date

10/26/00

20c. Location - City or Town, State

Towson, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, MD 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Diabetes Mellitus
Due to (or as a consequence of):c. Myocardial Degeneration
Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DementiaArterio Sclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

046412

29d. Date signed (Month, Day, Year)

10/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hilary Kim

319 S. Union Ave

Hdg

mm

21078

31. Date filed (Month, Day, Year)

OCT 25 2000

32. Registrar's Signature

State
RegistrarBodycombe, Martha S.
Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

SECRET

DEC 6 8 130

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend item#23a HCHD 10-25-00 Certificate of Death brh Reg. No. 00 35881

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Earl Charles Bowers
2. Date of Death Month Day Year Oct. 19, 2000
3. Time of Death 10:15 AM

4a. Facility Name (If not institution, give street and number) Oak Crest Village Care Center
4b. City, Town, or Location of Death Parkville
4c. County of Death Baltimore

Funeral
Director

5. Social Security Number 203-10-4364
6. Sex 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday) 80 Yrs.
8. Date of Birth (Month, Day, Year) Aug. 5, 1920
9. Birthplace (State or Foreign Country) Pennsylvania

Usual Residence of Decedent
10a. State Maryland
10b. County Baltimore
10c. City, Town or Location Baltimore
10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 8800 Walther Blvd., Apt. 4306
10f. Zip Code 21234
10g. Citizen of What Country? USA

11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1944 1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Supervisor
16b. Kind of Business/Industry Airplane Manufacturing

17. Father's Name (First, Middle, Last) Charles Earl Bowers
18. Mother's Name (First, Middle, Maiden Surname) Florence Bell Kepner

19a. Informant's Name/Relationship (Type, Print) Almeda Bowers/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Walther Blvd., Apt. 4306, Baltimore, MD 21234

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gardens
20c. Location - City or Town, State 10/23/00 Bel Air, Maryland

21. Signature of Funeral Service Licensee [Signature]
22. Name and Address of Facility McComas Funeral Home, P.A. 50 West Broadway Street, Bel Air, MD 21014

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death) a. Renal Failure Due to (or as a consequence of): 5 years
b. Hypertension Due to (or as a consequence of): 25 years
c. Diabetes Mellitus Due to (or as a consequence of): years
d. Atherosclerotic Vascular Disease years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Diabetes Mellitus, Atherosclerotic Vascular Disease
23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier [Signature]
29c. License number D34941
29d. Date signed (Month, Day, Year) Oct. 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan G. Weiner MD 8800 Walther Blvd Parkville, Md 21234

State
Registrar

31. Date filed (Month, Day, Year) OCT 25 2000
32. Registrar's Signature [Signature]

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760, BH

1341

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35882

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Katherine A. Belvin				2. Date of Death Month Day Year October 20, 2000		3. Time of Death 8:05 A. M.	
	4a. Facility Name (If not institution, give street and number) Manor Care - Rossville				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-01-6273		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 20, 1906	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 2 Elinor Avenue		10f. Zip Code 21236	
	10g. Citizen of What Country? U. S. A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress				16b. Kind of Business/Industry Clothing Company			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Jane Unknown			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Joan Bieschke (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Elinor Avenue, Baltimore, Maryland 21236			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Most Holy Redeemer		20c. Location - City or Town, State 10/23/00 Baltimore, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Schmunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CEREBROVASCULAR ACCIDENT						Approximate Interval Between Onset and Death 1 WEEK	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION, CONGESTIVE CARDIOMYOPATHY						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier  D.O.	
	29c. License number H35593						29d. Date signed (Month, Day, Year) OCT. 20, 2000	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. JOHN J. LOH 1124 MACE AVE., BALTIMORE, MD. 21221						31. Date filed (Month, Day, Year) OCT 24 2000	
	32. Registrar's Signature 						33. State Registrar	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35883

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gloria Christine Bollinger				2. Date of Death Month Day Year 10 26 00		3. Time of Death 17:20		
	4a. Facility Name (If not institution, give street and number) Carroll County General Hospital				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll		
Funeral Director	5. Social Security Number 215-32-6751	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan 20 1935		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County Carroll		10c. City, Town or Location Keymar			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 2523 South Baumgardner Rd				10f. Zip Code 21757		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/Operator		16b. Kind of Business/Industry Gloria's Glamour Corner				
	17. Father's Name (First, Middle, Last) David Luthur Keeney				18. Mother's Name (First, Middle, Maiden Surname) Mabel Clabaugh				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Michael Bollinger/husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2523 S. Baumgardner Rd Keymar, MD 21757				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Keysville Cemetery		Date 10/30/2000		20c. Location - City or Town, State Keysville, Maryland		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gram negative Sepsis & shock Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure non OMI Non Insulin dependent DM Sleep apnea, morbid obesity						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier D. B. Kalararia MD		29c. License number D23015		29d. Date signed (Month, Day, Year) 10/26/2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DINESH S. KALARIA 217 Washington Heights Westminster, Md 21157									
State Registrar	31. Date filed (Month, Day, Year) OCT 27 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35884

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ronald Lee Broadman, Jr.

2. Date of Death
Month Day Year

October 26 2000

3. Time of Death

3:40 A

Funeral
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

216-86-7643

6. Sex
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

24

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

April 15, 1976

9. Birthplace (State or Foreign
Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

136 Faywood Avenue

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Packaging

17. Father's Name (First, Middle, Last)

Ronald Lee Broadman, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Doris Cecelia Redman

19a. Informant's Name/Relationship (Type, Print)

Mrs. Doris Broadman (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

136 Faywood Avenue Glen Burnie, MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lake View Memorial Park

Date

10/28/00

20c. Location - City or Town, State

Sykesville, MD

21. Signature of Funeral Service Licensee

Brian D. Haight

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL PA (Box 195)
Sykesville, MD 21784 (410)-795-140023a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Viral cardiomyopathy
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

6 months.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

cerebral palsy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D44973

29d. Date signed (Month, Day, Year)

Oct 26 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gurmeet Singh Sawhney, M.D., 301 Hospital Drive, Glen Burnie, MD 21061

State
Registrar

31. Date filed (Month, Day, Year)

OCT 30 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Broadman, Ronald L.
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
document.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35885

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Martin Bennett				2. Date of Death Month Day Year October 25, 2000		3. Time of Death 12:10am	
	4a. Facility Name (If not institution, give street and number) 5607 Elele Court				4b. City, Town, or Location of Death Sykesville		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 093-34-8915		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) July 12, 1944	
	9. Birthplace (State or Foreign Country) New York		10a. State MD		10b. County Carroll		10c. City, Town or Location Sykesville	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 5607 Elele Court		10f. Zip Code 21784		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry Transportation			
	17. Father's Name (First, Middle, Last) Albert Martin Bennett				18. Mother's Name (First, Middle, Maiden Surname) Helen McComb			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) (Wife) Mrs. Linda Lee Weatherly Bennett				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5607 Elele Court Sykesville, MD 21784			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Mem. Park		20c. Date 10/28/00		20d. Location - City or Town, State Marriottsville, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Brian A. Haight				22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL PA (Box 195) Sykesville, MD 21784 (410)-795-1400			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarct Due to (or as a consequence of): Hypertension Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Approximate Interval Between Onset and Death							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Linda Weatherly				29c. License number 857896		29d. Date signed (Month, Day, Year) 10/25/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda Weatherly 5635 Old Court Rd Ellicott City MD 21038							
State Registrar	31. Date filed (Month, Day, Year) OCT 30 2000		32. Registrar's Signature B. Sparks					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35886

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leone Catherine Brown						2. Date of Death Month Day Year OCTOBER 22, 2000		3. Time of Death 1220 P.M.	
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital						4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 216-66-0730		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) Oct 7, 1909		9. Birthplace (State or Foreign Country) WV	
	Usual Residence of Decedent									
10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 18 Boone Street				10f. Zip Code 21502		10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) 12 Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home				
17. Father's Name (First, Middle, Last) John Taylor						18. Mother's Name (First, Middle, Maiden Surname) Sally (Crock)				
19a. Informant's Name/Relationship (Type, Print) Alma M. Kesner daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Boone Street; Cumberland MD 21502				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Memorial Park		Date 10/25		20c. Location - City or Town, State Cumberland, MD		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Searpelli Funeral Home, P.A. Cumberland, MD 21502				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)										Two Days
Due to (or as a consequence of):										
BIVENTRICULAR CONGESTIVE HEART FAILURE										Two Months
Due to (or as a consequence of):										
CNO - STAGE										
DILATED CARDIOMYOPATHY										One Year
Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 						29c. License number D33417 (md)		29d. Date signed (Month, Day, Year) OCTOBER 23, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES R. MOEN, M.D. 1068 NATIONAL HIGHWAY LAVALE, MARYLAND 21502										
31. Date filed (Month, Day, Year) OCT 25 2000		32. Registrar's Signature 								

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35887

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPH AUGUSTUS BECKER				2. Date of Death Month Day Year OCTOBER 31 2000		3. Time of Death 1:40AM		
	4a. Facility Name (If not institution, give street and number) 14212 CUNNINGHAM DRIVE S.W.				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY		
Funeral Director	5. Social Security Number 216-22-7054		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) JAN 1 1927		
	10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-1947		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry AETNA LUMBER CO.			
17. Father's Name (First, Middle, Last) JOSEPH PETER BECKER				18. Mother's Name (First, Middle, Maiden Surname) RACHEL CARR HOLLENBERGER					
19a. Informant's Name/Relationship (Type, Print) LEATRICE JOY BECKER WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14212 CUNNINGHAM DRIVE S.W. CUMBERLAND MD. 21502					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) ROCKY GAP VET CEMETERY NOV 2 2000 RFD FLINTSTONE MD.		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic colon CA to brain Due to (or as a consequence of): b. Colon Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number D 55079		29d. Date signed (Month, Day, Year) OCTOBER 31, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR PAULA WADDY 47 VIRGINIA AVE CUMBERLAND MARYLAND 21502									
31. Date filed (Month, Day, Year) NOV 01 2000				32. Registrar's Signature 					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35888

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN GERALD BURKE				2. Date of Death Month Day Year OCTOBER 28, 2000		3. Time of Death 2045		
	4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY		
Funeral Director	5. Social Security Number 198-16-8789		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) JULY 16, 1924		
	9. Birthplace (State or Foreign Country) PENNSYLVANIA		10a. State MD		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 562 FAYETTE STREET		10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LICENSED PRACTICAL NURSE		16b. Kind of Business/Industry HOSPITAL		17. Father's Name (First, Middle, Last) JOHN BURKE		18. Mother's Name (First, Middle, Maiden Surname) MAMIE CLARKE	
19a. Informant's Name/Relationship (Type, Print) KATHLEEN BURKE / WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 562 FAYETTE ST., CUMBERLAND, MD 21502		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SS. PETER & PAUL CEM.		20c. Location - City or Town, State 10/31/2000 CUMBERLAND, MD	
21. Signature of Funeral Service Licentiate 		22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Adenocarcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate interval Between Onset and Death 1 month			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Rheumatoid Arthritis Arteriosclerosis		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D12532		29d. Date signed (Month, Day, Year) October 30, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Breza, M.D. - 912 Seton Drive, Cumberland, MD 21502		31. Date filed (Month, Day, Year) NOV 01 2000		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-524-0054.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

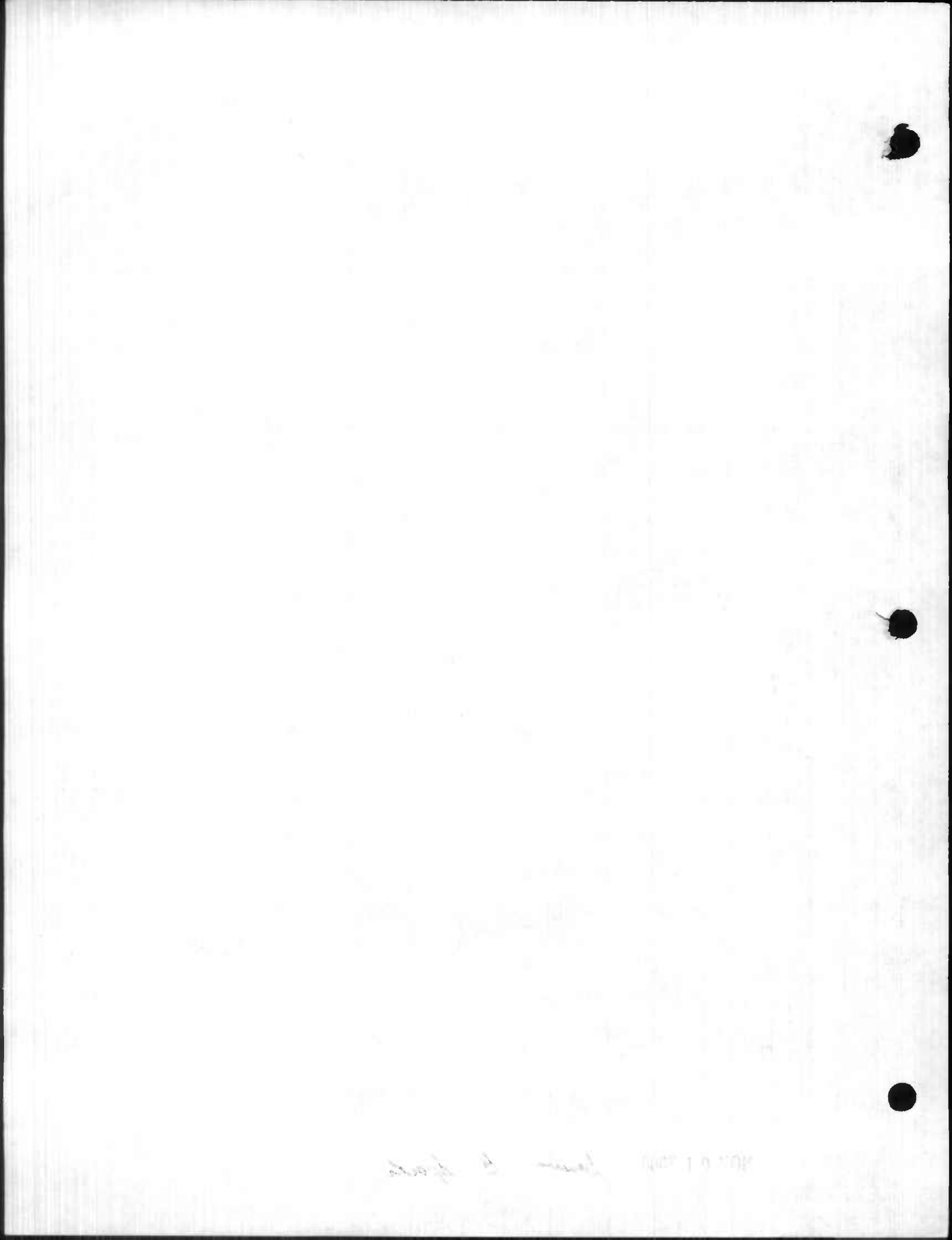
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 5 per fh G791 1/2/01 yf

State of Maryland / Department of Health and Mental Hygiene

00 35889

AMEND ITEM: #26 PER FH G789 11-29-00 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Julia Banks		2. Date of Death Month Day Year September 30, 2000		3. Time of Death 7:55 AM
	4a. Facility Name (If not institution, give street and number) 3080 Whispering Drive		4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert
Funeral Director	5. Social Security Number 123-30-1779	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	8. Date of Birth (Month, Day, Year) January 7, 1912	9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County St. Mary's	10c. City, Town or Location Hollywood		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 45283 Nats Creek Road		10f. Zip Code 20636		10g. Citizen of What Country? U.S.A.
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) 12th		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales		16b. Kind of Business/Industry Womens Dresses		17. Father's Name (First, Middle, Last) Anton Reiner
	18. Mother's Name (First, Middle, Maiden Surname) Julia Torok		19. Informant's Name/Relationship (Type, Print) Dennis Banks (Son)		
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rood Cemetery		20c. Location - City or Town, State 10/3/00 Westbury, New York
	21. Signature of Funeral Service Licensee <i>Richard H. Gardiner</i>		22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650		
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Myocardial Infarction</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimer's dementia</i>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) CARETAKER'S		
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>David Gallatin</i>
	29c. License number D57949		29d. Date signed (Month, Day, Year) 9/30/00		
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Gallatin, MD Prince Frederick, Maryland				31. Date filed (Month, Day, Year) OCT 3 2000
	32. Registrar's Signature <i>B. Sparks</i>				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #9 PER F.H. G791 State of Maryland / Department of Health and Mental Hygiene
1-24-01 WR.

00 35890

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carson Joe Bynaker				2. Date of Death Month Day Year October 16, 2000		3. Time of Death 7:54AM
	4a. Facility Name (If not institution, give street and number) 25200 Allies Way				4b. City, Town, or Location of Death Hollywood		4c. County of Death St. Mary's
Funeral Director	5. Social Security Number 225-32-7873	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) December 10, 1929	9. Birthplace (State or Foreign) VIRGINIA
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County St. Mary's	10c. City, Town or Location Hollywood			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 25200 Allies Way			10f. Zip Code 20636		10g. Citizen of What Country? U S A	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steamfitter		16b. Kind of Business/Industry Union
	17. Father's Name (First, Middle, Last) Samuel Bynaker				18. Mother's Name (First, Middle, Maiden Surname) Martha Shirkey		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Patricia G. Bynaker (Spouse)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25200 Allies Way, Hollywood, Maryland 20636			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 10/19/00	20c. Location - City or Town, State Alexandria, Virginia	
	21. Signature of Funeral Service Licensee <i>Michael R. Gardner</i>			22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Artery Disease Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Atherosclerosis Due to (or as a consequence of): d. Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 10Yr.
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Th...</i>			29c. License number D34533		29d. Date signed (Month, Day, Year) 10.16.00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHALID M Husni MD 22576 Munster Boulevard California MD 20615							
31. Date filed (Month, Day, Year) OCT 17 2000		32. Registrar's Signature <i>B. Jones</i>					

ORIGINAL

Handwritten signature

000574700

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35891

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Ferdinand Cahn

2. Date of Death

Month Day Year
October 26, 2000

3. Time of Death

5:15 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Chesapeake Woods Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

102-20-4427

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 3, 1925

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

218 Killarney Road

10f. Zip Code

21613

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Certified Public Accountant

16b. Kind of Business/Industry

Accounting

17. Father's Name (First, Middle, Last)

Oscar Lee Cahn

18. Mother's Name (First, Middle, Maiden Surname)

Florence Guth

19a. Informant's Name/Relationship (Type, Print)

Charlotte E. Cahn Former Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

218 Killarney Road Cambridge, Maryland 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veterans Cemetery

Date

10/30/00

20c. Location - City or Town, State

Cambridge, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Thomas Funeral Home, P.A.
700 Locust Street Cambridge, Maryland 21613

23a. Pertinent enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Arteriosclerotic Heart disease

Due to (or as a consequence of):

b. Advance Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

year

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number

D47924

29d. Date signed (Month, Day, Year)

10-26-00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

NOMAN THANWY 300 AURORA STREET CAMBRIDGE MD 21613

31. Date filed (Month, Day, Year)

OCT 27 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature or initials.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35892

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Smith Coale				2. Date of Death Month Day Year 10 23 2000				3. Time of Death 12:20 a.m.		
	4a. Facility Name (If not institution, give street and number) Carroll Lutheran Village				4b. City, Town, or Location of Death Westminster				4c. County of Death Carroll		
Funeral Director	5. Social Security Number 214-16-6292		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) May 8, 1909		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent				10a. State Maryland				10b. County Carroll		10c. City, Town or Location Sykesville
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 1090 Montclare Drive				10f. Zip Code 21784		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Budget Analyst				16b. Kind of Business/Industry U.S. Government			
17. Father's Name (First, Middle, Last) William N. Coale				18. Mother's Name (First, Middle, Maiden Surname) Laura Bristow							
19a. Informant's Name/Relationship (Type, Print) Elizabeth Ann Glover (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1090 Montclare Dr., Sykesville, MD 21784							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Angel Hill Cemetery				Date 10/27/00		20c. Location - City or Town, State Havre de Grace, MD	
21. Signature of Funeral Service Licensee Husken Amy Unglesbee				22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End Stage Myelodysplastic Disease Due to (or as a consequence of): b. Severe Thrombocytopenia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2 yrs 2 yrs			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Anemia, Dysphagia				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier				29c. License number D37949		29d. Date signed (Month, Day, Year) Oct-23rd 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alexander Bugher, 2015 Sevier Ave Suite 307, Westminister MD 21157				31. Date filed (Month, Day, Year) OCT 26 2000				32. Registrar's Signature B. Sparks			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35893

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JULIA DOUGHTY CLATCHEY		2. Date of Death Month 10 Day 27 Year 2000		3. Time of Death 11:45 AM
	4a. Facility Name (If not institution, give street and number) Carroll County General hospital		4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll
Funeral Director	5. Social Security Number 218-22-5973	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	8. Date of Birth (Month, Day, Year) Sept. 06, 1925	
	9. Birthplace (State or Foreign Country) Tennessee		10a. State Maryland		
To Be Completed by Funeral Director	10b. County Carroll		10c. City, Town or Location Hampstead		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 3195 Shamer Lane		10f. Zip Code 21074		10g. Citizen of What Country? United States
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker
	16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) Benjamin Lee Doughty		18. Mother's Name (First, Middle, Maiden Surname) Ina Johnson
	19a. Informant's Name/Relationship (Type, Print) Verna Hollingsworth (Niece)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3195 Shamer Lane, Hampstead, Maryland 21074		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Park		20c. Location - City or Town, State 10/31/00 Glen Burnie, Md.
	21. Signature of Funeral Service Licensee Stevens WE		22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, Md. 21074		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Asystole Ischemic Cardiomyopathy				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier Khalil Freisi MD		29c. License number D38915		29d. Date signed (Month, Day, Year) 10/27/2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHALIL FREISI 295 Stoner Ave westminster MD 21157				
	31. Date filed (Month, Day, Year) OCT 30 2000		32. Registrar's Signature Benjamin B Sparks		

2000 11-17-00

11-27-00
11-27-00

11-27-00 11-27-00 11-27-00

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35894

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sylvia

Chase

2. Date of Death

Month

Day

Year

Oct

31st

2000

3. Time of Death

12 16 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Hebrew Home of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

152-28-7340

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 15, 1915

9. Birthplace (State or Foreign Country)

Lithuania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9113 Cranford Drive

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

License Practice Nurse

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Chaim

Kozlowsky

18. Mother's Name (First, Middle, Maiden Surname)

Channa

Abelovicz

19a. Informant's Name/Relationship (Type, Print)

Helene Bayder (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Riverside Cemetery

Date

11/2/2000

20c. Location - City or Town, State

Saddle Brook, N.J.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction

Due to (or as a consequence of):

b. Coronary artery disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

atrial fibrillation Non-Insulin dependent diabetes

chronic cerebral vascular disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D:44502

29d. Date signed (Month, Day, Year)

Oct 31st 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Consuelo Alvarez, M.D.
6121 Montrose Road, Rockville, MD 20852State
Registrar

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35895

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ianes Mae Collins

2. Date of Death

October 29, 2000

3. Time of Death

12:00 pm

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

219-26-1029

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jul 20, 1937

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9 King Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

David Sulser

18. Mother's Name (First, Middle, Maiden Surname)

Madelene Ianes

19a. Informant's Name/Relationship (Type, Print)

Marvin A. Collins Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 King Street; Cumberland MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunset Memorial Park

Date

11/01

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee


Scarpelli Funeral Home, P.A.
Cumberland, MD 21502Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease

5 years

Due to (or as a consequence of):

b. Peripheral vascular disease

2 years

Due to (or as a consequence of):

c. Diabetes mellitus

10 years

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident
3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

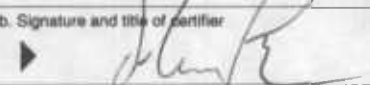
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 36766

29d. Date signed (Month, Day, Year)

October 30, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Vik Poonai, 920 National Highway, LaVale, MD 21502

State
Registrar

31. Date filed (Month, Day, Year)

OCT 30 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

IANES COLLINS 219-26-1029

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Handy C. Smith

MS. A. 1. 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35896

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alfonso A. Campolattaro				2. Date of Death Month November Day 5 Year 2000		3. Time of Death 10^{am}	
	4a. Facility Name (If not institution, give street and number) 28 West Allegheny Avenue Apt 1503				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 573 82 7013		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) Jan 4, 1933	
	9. Birthplace (State or Foreign Country) Italy		10a. State MD		10b. County Baltimore		10c. City, Town or Location Towson	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 28 West Allegheny Ave Apt 1503		10f. Zip Code 21204		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Professor		16b. Kind of Business/Industry Education				
17. Father's Name (First, Middle, Last) Augusto Campolattaro				18. Mother's Name (First, Middle, Maiden Surname) Maria Pace				
19a. Informant's Name/Relationship (Type, Print) Dario Campolattaro/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13092 Monica Court Fairfax, Virginia 22030				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 11-6-2000		20c. Location - City or Town, State Catonsville, MD		
21. Signature of Funeral Service Licensee Sharon A. Collins-Wyle		22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIORESPIRATORY ARREST Due to (or as a consequence of): b. Hypertension CARDIOVASCULAR Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cirrhosis, Prob. Peptic ulcer disease, C.O.P.D.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Dr. C. P. ...				29c. License number D-0023732		29d. Date signed (Month, Day, Year) Nov. 6, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) F.P. ... 516 BALT. PIKE, Bal Air Md. 21014								
31. Date filed (Month, Day, Year) NOV 08 2000		32. Registrar's Signature Anna B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #8 PER F.H. G789 11-20-00 State of Maryland / Department of Health and Mental Hygiene

00 35897

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles E. Channing, Jr.				2. Date of Death Month October Day 20 Year 2000				3. Time of Death 11:10am	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda, MD				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577242506		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) 12-11-1918		9. Birthplace (State or Foreign Country) Virginia		10a. State MD		10b. County Montgomery		10c. City, Town or Location Potomac	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 8810 Belmont RD		10f. Zip Code 20854		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4or 5+) 5+		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Attorney		16b. Kind of Business/Industry Law		17. Father's Name (First, Middle, Last) Charles Edwards Channing		18. Mother's Name (First, Middle, Maiden Sumama) Lucy Faulkner		19a. Informant's Name/Relationship (Type, Print) Roxanne Bachowski/Daughter		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8810 Belmont RD, Potomac, MD 20854		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cramation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) National Memorial Park		20c. Location - City or Town, State 102400 Falls Church, VA		21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisconsin Ave NW, Washington, DC 20016		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. lung cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 3 months		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		
28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D43083		29d. Date signed (Month, Day, Year) October 21, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE A SOTOS, MD 9707 Medical Center Dr #300 Rockville MD 20850		
31. Data filed (Month, Day, Year) OCT 23 2000		32. Registrar's Signature 		33. State Registrar		34. State Registrar		35. State Registrar		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35898

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DON HOWARD CARROLL

2. Date of Death

Month Day Year
October 28 2000

3. Time of Death

08:15 am

4a. Facility Name (If not institution, give street and number)

4003 14th Street

4b. City, Town, or Location of Death

Chesapeake Beach

4c. County of Death

Calvert

Funeral
Director

5. Social Security Number

411 40 4606

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug 6, 1932

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Chesapeake Beach

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4003 14th Street

10f. Zip Code

20732

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1948-69

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

construction machinery supv.

16b. Kind of Business/Industry

U.S. Army

17. Father's Name (First, Middle, Last)

James Don

Carroll

18. Mother's Name (First, Middle, Maiden Surname)

Marie James Caudle

19a. Informant's Name/Relationship (Type, Print)

Jo-Ann Scheitlin, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as # 10 above

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

10-30-00

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

Charles F. Bell

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

hours

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

S/P CABG 6 months ago

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Angela Fowler-Brown

29c. License number

D0052533

29d. Date signed (Month, Day, Year)

10/30/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Angela Fowler-Brown 89th MDOS/SGOPP Andrews AFB, MD 20762

31. Date filed (Month, Day, Year)

NOV 01 2000

32. Registrar's Signature

Benita B Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35899

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Joseph Whitmore Dean</i>						2. Date of Death Month <i>October</i> Day <i>26</i> Year <i>2000</i>		3. Time of Death <i>14:39</i>	
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical System</i>						4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore City</i>	
Funeral Director	5. Social Security Number <i>212-60-8244</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>45</i>		8. Date of Birth (Month, Day, Year) <i>March 31 1955</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>	
	Usual Residence of Decedent									
10a. State <i>MD</i>		10b. County <i>Dorchester</i>		10c. City, Town or Location <i>Cambridge</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <i>921 Race St.</i>				10f. Zip Code <i>21613</i>		10g. Citizen of What Country? <i>U.S.A.</i>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>white</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>2</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>supervisor</i>			16b. Kind of Business/Industry <i>glass tubing mfg.</i>			
17. Father's Name (First, Middle, Last) <i>George Edward Dean</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Ethel Bandy</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Frances W. Dean - wife</i>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>921 Race St., Cambridge MD 21613</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Dorchester Memorial Park</i>		20c. Location - City or Town, State <i>Cambridge, Md.</i>		20d. Date <i>10-31-00</i>		
21. Signature of Funeral Service Licensee <i>Kenneth R. Thomas Jr.</i>				22. Name and Address of Facility <i>Thomas Funeral Home PA 700 Locust St., Cambridge MD 21613</i>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>Cor pulmonale</i> Due to (or as a consequence of):</p> <p>b. <i>Obstructive sleep apnea</i> Due to (or as a consequence of):</p> <p>c. <i>Morbid obesity</i> Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Atrial fibrillation</i> <i>Chronic obstructive pulmonary disease</i>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>J. R. Hou</i>				29c. License number <i>P12417</i>		29d. Date signed (Month, Day, Year) <i>October 26, 2000</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Jean R. Hou 22 South Greene Street, Baltimore, MD 21236</i>										
31. Date filed (Month, Day, Year) <i>OCT 30 2000</i>		32. Registrar's Signature <i>B. Sparks</i>								

To Be Completed by Funeral Director

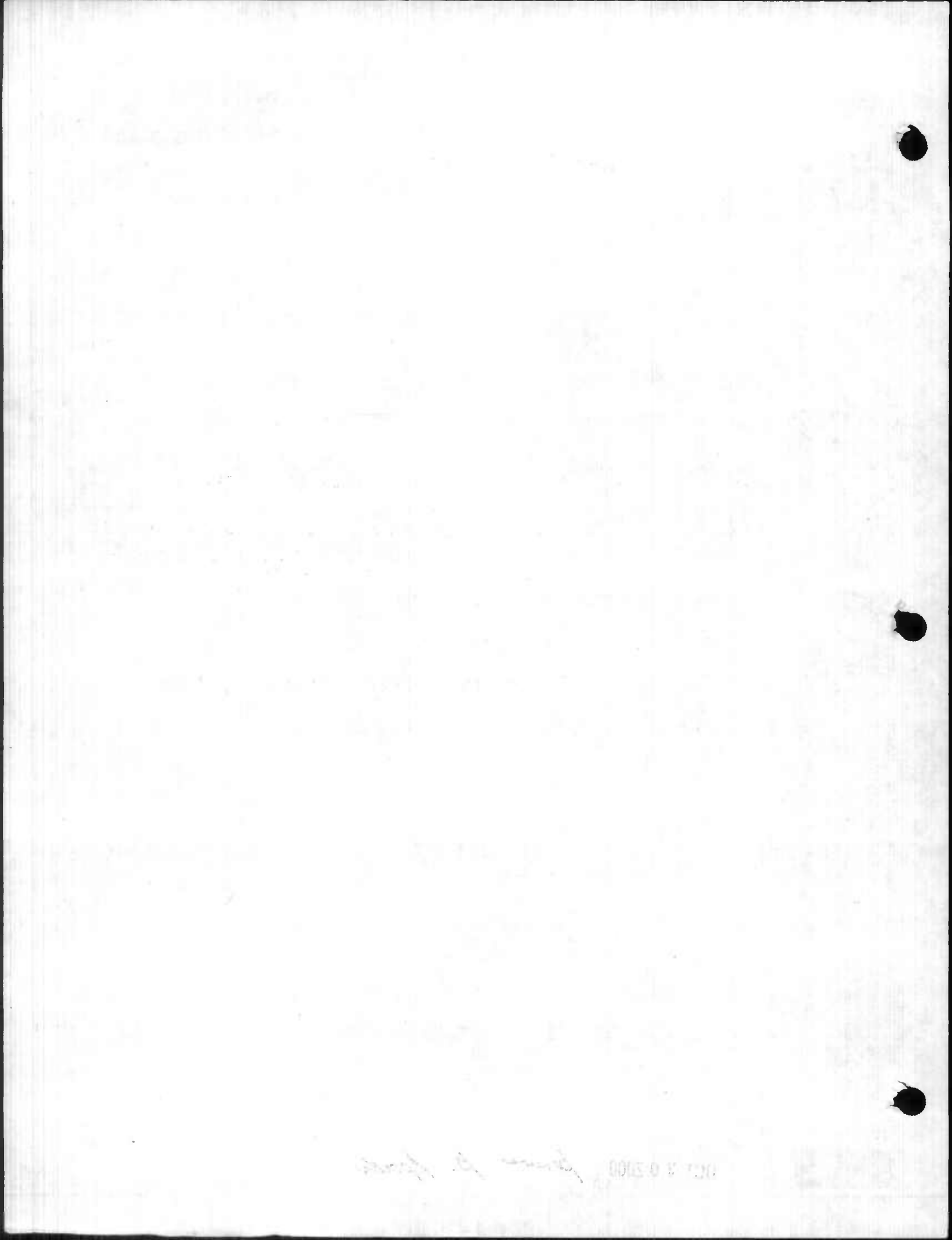
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35900

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rita Augusta Deaner				2. Date of Death Month Day Year October 21, 2000				3. Time of Death 2030	
	4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital				4b. City, Town, or Location of Death Havre de Grace				4c. County of Death Harford	
Funeral Director	5. Social Security Number 215-42-8402	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 16, 1944		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent									
10a. State Maryland		10b. County Harford		10c. City, Town or Location Havre de Grace				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 2101 Chapel Road				10f. Zip Code 21078		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry Real Estate		
17. Father's Name (First, Middle, Last) Ralph Coen				18. Mother's Name (First, Middle, Maiden Surname) Esther Stephens						
19a. Informant's Name/Relationship (Type, Print) Richard Deaner III (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 Chadsworth Court, Aberdeen, Maryland 21001						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Harford Memorial Gardens		Date 10/26		20c. Location - City or Town, State Aberdeen, Maryland		
21. Signature of Funeral Service Licensee Hirsken Anup Unglesbee				22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
								24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier				29c. License number		
				29d. Date signed (Month, Day, Year) 10/22/00						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. Deaner III, 319 E. Main St., Havre de Grace, MD, 21078										
31. Date filed (Month, Day, Year) OCT 25 2000				32. Registrar's Signature B. Sparks						

ORIGINAL

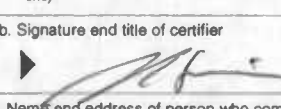
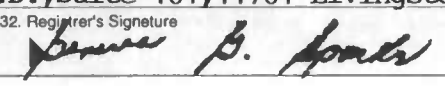
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35901

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Naomi E. Dennis				2. Date of Death Month Day Year October 25, 2000		3. Time of Death 10:15 PM	
	4a. Facility Name (If not institution, give street and number) Fort Washington Hospital				4b. City, Town, or Location of Death Fort Washington		4c. County of Death Prince George	
Funeral Director	5. Social Security Number 462-40-0862		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 3, 1905	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				10a. State Maryland		10b. County Prince George	
To Be Completed by Funeral Director	10c. City, Town or Location Fort Washington				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 11207 Livingston Road	
	10f. Zip Code 20744				10g. Citizen of What Country? U.S.A.		10h. Merit Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tailor		16b. Kind of Business/Industry Dept. Store	
	17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Mears			
	19a. Informant's Name/Relationship (Type, Print) Robert D. Crim Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Funeral Service		20c. Location - City or Town, State Alexandria, Virginia	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. 20640			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Coronary Heart Failure Due to (or as a consequence of): f. Pneumonia Due to (or as a consequence of): g. Atherosclerotic Heart Disease Due to (or as a consequence of): h. Due to (or as a consequence of):				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: 4 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				
28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				
29c. License number 1745365				29d. Date signed (Month, Day, Year) 10-26-00				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Michael Sidarow, M.D., Suite 101, 11701 Livingston Road, Ft. Washington, Maryland				31. Date filed (Month, Day, Year) OCT 27 2000				
32. Registrar's Signature 				33. Registrar's Title 20744				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35902

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGARET MARIE DAWSON					2. Date of Death Month Day Year OCT. 18, 2000		3. Time of Death 6:00 AM		
	4a. Facility Name (If not institution, give street and number) 685 FAYETTE STREET					4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY		
Funeral Director	5. Social Security Number 220-10-7645		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) OCT. 2, 1920		9. Birthplace (State or Foreign Country) OHIO	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 685 FAYETTE STREET				10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CAFETERIA WORKER			16b. Kind of Business/Industry ALLEGANY COUNTY BOARD OF EDUCATION		
	17. Father's Name (First, Middle, Last) MARTIN LUTHER CONROD					18. Mother's Name (First, Middle, Maiden Summa) PANSY THELMA TWIGG				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) THELMA ROWE/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 N. THIRD STREET, LAVALE, MD 21502					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) SUNSET MEMORIAL PARK		Date 10/20/2000		20c. Location - City or Town, State CUMBERLAND, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Meningeal lymphoma with paraplegia Due to (or as a consequence of): b. Lymphoma Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 3 months 12 months									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypothyroid									
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 					29c. License number D17526		29d. Date signed (Month, Day, Year) October 18, 2000		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Mehanna, M.D., 902 Seton Drive, Cumberland, MD 21502									
31. Date filed (Month, Day, Year) OCT 19 2000										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35903

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lola Dare				2. Date of Death Month Oct. Day 26 , Year 2000		3. Time of Death 13:23 PM	
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 214-07-5917		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) March 12, 1915	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Allegany		10c. City, Town or Location Lonaconing	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 61 High Street		10f. Zip Code 21539		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Labor		16b. Kind of Business/Industry Nursing Home			
	17. Father's Name (First, Middle, Last) William Timney				18. Mother's Name (First, Middle, Maiden Surname) Della Fairgrieve			
	19a. Informant's Name/Relationship (Type, Print) Della Lynn Kirkwood--Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21306 Waterstation Run Road S.W., Lonaconing, Md. 21539			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Laurel Hill Cemetery		Date October 28, 2000		20c. Location - City or Town, State Moscow Mills, Md.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A., Lonaconing, Md. 21539			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bleeding Abdominal Aortic Aneurysm Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death 4 hours							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Piece of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day, Year)								
28b. Time of Injury M								
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 								
29c. License number 021488								
29d. Date signed (Month, Day, Year) Oct. 26, 2000								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Thomas J. Declin MD, 20 Douglas Ave, Lonaconing, Md. 21539								
31. Date filed (Month, Day, Year) OCT 30 2000								
32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35904

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HELEN MARIE DOLLY						2. Date of Death Month October Day 31 Year 2000		3. Time of Death 13:50PM	
	4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL						4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 220-34-2102		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) MARCH 30 1939		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
10a. State MARYLAND			10b. County ALLEGANY			10c. City, Town or Location FLINTSTONE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 13101 BLUE GRASS DRIVE						10f. Zip Code 21530		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOME MAKER			16b. Kind of Business/Industry HOME MAKER	
17. Father's Name (First, Middle, Last) PAUL THEODORE BECKWITH						18. Mother's Name (First, Middle, Maiden Surname) AGNES CECELIA SHAFFER				
19a. Informant's Name/Relationship (Type, Print) DONALD L. DOLLY SR. HUSBAND						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13101 BLUE GRASS DRIVE FLINTSTONE MD. 21530				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)						20b. Place of Disposition (Name of cemetery, crematory or other place) GLENDAL CEMETERY NOV 3 2000			20c. Location - City or Town, State FLINTSTONE MARYLAND	
21. Signature of Funeral Service Licensee <i>Dale L. Merritt</i>						22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION										SIX HOURS
Due to (or as a consequence of): CORONARY ARTERY DISEASE										TEN YEARS
Due to (or as a consequence of):										
Due to (or as a consequence of):										
Due to (or as a consequence of):										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE DIABETES										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature]</i>						29c. License number D33417(MD)		29d. Date signed (Month, Day, Year) November 1, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES R. MOEN, M.D. 1068 NATIONAL HIGHWAY LAVALE, MD 21502										
31. Date filed (Month, Day, Year) NOV 01 2000			32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 200-655-1100.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

amend item 23a, pt II, 27, 28a, b, c, d, e, per me G789 11/20/2000 **Certificate of Death**

Reg. No. 00 35905

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nancy L. Denton-Korolewski				2. Date of Death Month: NOVEMBER Day: 04, Year: 2000		3. Time of Death 11:10 P.M.								
	4a. Facility Name (If not institution, give street and number) 1916 PUMPHANDLE COURT				4b. City, Town, or Location of Death CROWNSVILLE		4c. County of Death ANNE ARUNDEL								
Funeral Director	5. Social Security Number 578-62-9086		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) July 25, 1953		9. Birthplace (State or Foreign Country) Washington, DC						
	Usual Residence of Decedent														
10a. State Maryland			10b. County Anne Arundel			10c. City, Town or Location Crownsville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
10e. Street and Number 1916 Pumphandle Court					10f. Zip Code 21032		10g. Citizen of What Country? USA								
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 yrs.				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager			16b. Kind of Business/Industry Construction								
17. Father's Name (First, Middle, Last) Frederick L. Denton					18. Mother's Name (First, Middle, Maiden Surname) Doris Beek										
19a. Informant's Name/Relationship (Type, Print) Kenneth S. Korolewski/ Husband					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1916 Pumphandle Court Crownsville, MD 21032										
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Date 11-8-00		20d. Location - City or Town, State Suitland, Maryland							
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. NARCOTIC INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE											
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) found: 11/4/00		28b. Time of Injury found: 8:53 P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unknown							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found: home				28f. Location (Street and Number or Rural Route Number, City or Town, State) 1916 Pumphandle Court, Crownsville, Anne Arundel County, Md											
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) NOVEMBER 05, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 													

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35906

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Anna Mary Evans</u>				2. Date of Death Month <u>October</u> Day <u>26</u> Year <u>2000</u>				3. Time of Death <u>16:10PM</u>		
	4a. Facility Name (If not institution, give street and number) <u>Sacred Heart Hospital</u>				4b. City, Town, or Location of Death <u>Cumberland</u>				4c. County of Death <u>Allegany</u>		
Funeral Director	5. Social Security Number <u>213-22-4517</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>73</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Dec 24, 1926</u>		9. Birthplace (State or Foreign Country) <u>MD</u>		
	10a. State <u>MD</u>		10b. County <u>Allegany</u>		10c. City, Town or Location <u>Frostburg</u>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <u>19016 Brick Row Road SW</u>					10f. Zip Code <u>21532</u>			10g. Citizen of What Country? <u>USA</u>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>white</u>			
15. Decedent's Education (Specify only highest grade completed) <u>12</u> Elementary/Secondary (0-12) <u>College</u> (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u>			16b. Kind of Business/Industry <u>Own Home</u>			
17. Father's Name (First, Middle, Last) <u>Pietro Scarpelli</u>					18. Mother's Name (First, Middle, Maiden Surname) <u>Marie nmn</u>						
19a. Informant's Name/Relationship (Type, Print) <u>Susan E. Miller daughter</u>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>19016 Brick Row Rd SW; Frostburg MD 21532</u>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Restlawn Memorial Gard</u>			20c. Location - City or Town, State <u>2000 LaVale, MD</u>			
21. Signature of Funeral Service Licensee <u>Nicholas J. Scarpelli</u>					22. Name and Address of Facility <u>Scarpelli Funeral Home, P.A. Cumberland, MD 21502</u>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. CARCINOMA OF PANCREAS</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>b. Due to (or as a consequence of):</u> <u>c. Due to (or as a consequence of):</u> <u>d. Due to (or as a consequence of):</u>										Approximate Interval Between Onset and Death <u>4 months</u>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DIABETES MELLITUS, AND STAGE RENAL DISEASE</u>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <u>Robert [Signature]</u>				29c. License number <u>D31875</u>		29d. Date signed (Month, Day, Year) <u>OCTOBER 27, 2000</u>		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <u>140 902 Seton Drive Cumberland, Md. 21502</u>											
31. Date filed (Month, Day, Year) <u>OCT 30 2000</u>			32. Registrar's Signature <u>[Signature]</u>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

George B. Smith 425 N. 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35907

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

GERARD

NICHOLAS

FINIELLO

2. Date of Death

Month

Day

Year

OCT

27

2000

3. Time of Death

2:50 P.M.

4a. Facility Name (If not institution, give street and number)

ATLANTIC GENERAL HOSPITAL

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCESTER

5. Social Security Number

204-20-3305

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
8-27-1928

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

OCEAN VIEW

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

RD#1, Box 68A

10f. Zip Code

19970

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SALESMAN

16b. Kind of Business/Industry

REAL ESTATE

17. Father's Name (First, Middle, Last)

VITO FINIELLO

18. Mother's Name (First, Middle, Maiden Surname)

JENNIE LABRIOLA

19a. Informant's Name/Relationship (Type, Print)

MARY C. FINIELLO/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RD#1, BOX 68A, OCEAN VIEW, DE 19970

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)MELSON'S
CAPE HENLOPEN CREMATORY

Date

10-28-00

20c. Location - City or Town, State

FRANKFORD, DELAWARE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MELSON FUNERAL SERVICES, LTD.

WEST AVE., OCEAN VIEW, DE 19970

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Subarachnoid hemorrhage

Due to (or as a consequence of):

b. Metastatic lung cancer

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOAOther: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
injury28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. VAN VOORHEES, 34 FRANKLIN AVE. BERLIN, MD 21811

31. Date filed (Month, Day, Year)

OCT 30 2000

32. Registrar's Signature

Geneva B. Sparks

State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

[Faint, illegible text covering the page, likely bleed-through from the reverse side. The text is too light to transcribe accurately.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35908

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILBUR GORMAN FOURHMAN SR.				2. Date of Death Month OCT. Day 26 Year 2000		3. Time of Death 7:30 PM	
	4a. Facility Name (If not institution, give street and number) 1603 DAVINDA DR.				4b. City, Town, or Location of Death FINKSBURG		4c. County of Death CARROLL	
Funeral Director	5. Social Security Number 219-20-4258		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) 7/23/1926	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD.		10b. County CARROLL		10c. City, Town or Location FINKSBURG	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 1603 DAVINDA DR.			
	10f. Zip Code 21048				10g. Citizen of What Country? USA			
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MACHINE OPERATOR		16b. Kind of Business/Industry MANUFACTURING			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) JOHN FOURHMAN				18. Mother's Name (First, Middle, Maiden Surname) HETTIE SHIPLEY			
	19a. Informant's Name/Relationship (Type, Print) SON WILBUR G. FOURHMAN, JR.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 931 ROLLING RIDGE DR., WESTMINSTER, MD. 21157			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) EVERGREEN MEM. GARDENS		20c. Location - City or Town, State 10/30/00 FINKSBURG, MD.		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157							
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ventricular Fibrillation Due to (or as a consequence of): b. Atherosclerotic Heart Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death Subst 8 years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier 	
	29c. License number D78200		29d. Date signed (Month, Day, Year) 10/27/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHITRACHEDU NAGANNA MD. 700 A park rd westminster MD 21157			
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) OCT 30 2000		32. Registrar's Signature 					
	State Registrar							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35909

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margarete V. Fretwell				2. Date of Death Month Oct Day 25 Year 2000				3. Time of Death 08:15pm		
	4a. Facility Name (If not institution, give street and number) Allegany County Nursing Home				4b. City, Town, or Location of Death Cumberland				4c. County of Death Allegany		
Funeral Director	5. Social Security Number 217-10-4750		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) May 26, 1917		9. Birthplace (State or Foreign) WV		
	Usual Residence of Decedent										
10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 631 Shriver Avenue				10f. Zip Code 21502		10g. Citizen of What Country? USA					
11. Marital Status <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			16b. Kind of Business/Industry Textile				
17. Father's Name (First, Middle, Last) George W. Fretwell					18. Mother's Name (First, Middle, Maiden Surname) Annie (Samon)						
19a. Informant's Name/Relationship (Type, Print) Garry Imes nephew					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10403 Grandhaven Ave; Upper Marlboro MD 20772						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery		Date 10/27		20c. Location - City or Town, State 2000 Cumberland, MD				
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Scarpelli Funeral Home P.A. Cumberland, Maryland 21502								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death 8 YRS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 				29c. License number D-14865		29d. Date signed (Month, Day, Year) OCT. 25, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robustiano J. Barrera M.D. Mem. Hosp Med Bldg Cumberland MD 21502											
31. Date filed (Month, Day, Year) OCT 30 2000		32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

ms

State
Registrar

Page 2 of 2

OCT 10 1980

Amended #12, 11/1/00, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35910

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Joseph P. Firlie		2. Date of Death Month October Day 30 Year 2000		3. Time of Death 3:30 p.m.	
4a. Facility Name (If not institution, give street and number) 805 Braddock Road		4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
5. Social Security Number 218-38-2384		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.	
8. Date of Birth (Month, Day, Year) Nov 20, 1941		9. Birthplace (State or Foreign Country) MD			
10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 805 Braddock Road		10f. Zip Code 21502	
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1963 to 1970	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) supervisor		16b. Kind of Business/Industry State of Maryland		17. Father's Name (First, Middle, Last) Raphael Firlie	
18. Mother's Name (First, Middle, Maiden Surname) Eula (Liller)		19a. Informant's Name/Relationship (Type, Print) Grace Firlie		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 Braddock Road; Cumberland MD 21502	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SS Peter Paul Cemetery		20c. Location - City or Town, State 2000 Cumberland, MD	
21. Signature of Funeral Service Licensee Michael J. Scarpelli		22. Name and Address of Facility Scarpelli Funeral Home, P.A.		22. Address of Facility Cumberland, MD 21502	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Squamous cell carcinoma of head & neck Due to (or as a consequence of):		Approximate Interval Between Onset and Death 2 years			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 11/1/00		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Thomas E. Chappell		29c. License number D35135	
29d. Date signed (Month, Day, Year) October 31, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas E. Chappell, M.D.; 912 Seton Drive; Cumberland, MD 21502		31. Date filed (Month, Day, Year) NOV 01 2000	
32. Registrar's Signature Sparks					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: #26 PER PHY G&93 3-21-01 WR **Certificate of Death**

Reg. No.

00 35911

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD WAYNE FORD				2. Date of Death Month Day Year OCTOBER 19, 2000		3. Time of Death 6:00 A.M.	
	4a. Facility Name (If not institution, give street and number) 109 MAPLE AVENUE				4b. City, Town, or Location of Death BOONSBORO		4c. County of Death WASHINGTON	
Funeral Director	5. Social Security Number 218-62-8662	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) APRIL 22, 1953		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10e. State MARYLAND		10b. County WASHINGTON		10c. City, Town or Location BOONSBORO		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 109 MAPLE AVENUE				10f. Zip Code 21713		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CORRECTIONAL OFFICER		16b. Kind of Business/Industry STATE PRISON		
17. Father's Name (First, Middle, Last) PAUL BRYAN FORD JR.				18. Mother's Name (First, Middle, Maiden Surname) CATHERINE VIRGINIA SHIFLER				
19a. Informant's Name/Relationship (Type, Print) CONNIE M. FORD/SPOUSE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Maple Avenue, Boonsboro, Maryland 21713				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BOONSBORO CEMETERY		Date 10/22/2000		20c. Location - City or Town, State BOONSBORO, MARYLAND		
21. Signature of Funeral Service Licensee P. STEVEN DANFELT, JR.				22. Name and Address of Facility 7606 OLD NATIONAL PIKE BAST FUNERAL HOME BOONSBORO, MD 21713				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>probable myocardial infarction</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier William J. Hammond Jr MD				29c. License number 00055926		29d. Date signed (Month, Day, Year) 10/23/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William J. Hammond Jr 100 Greeting Lane Keedysville MD 21756								
31. Date filed (Month, Day, Year) OCT 23 2000		32. Registrar's Signature Beverly G Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

00 35912

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARGELIO (NMN) GARCIA				2. Date of Death Month Day Year October 16 2000		3. Time of Death 5:02pm	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-52-7606	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 8, 1910		9. Birthplace (State or Foreign Country) Cuba
	Usual Residence of Decedent							
10a. State Maryland		10b. County Harford		10c. City, Town or Location Joppa		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 717 Town Center Drive				10f. Zip Code 21085		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Cuban		14. Race - American Indian, Black, White, etc. Specify: Caucasian		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical Doctor		16b. Kind of Business/Industry Health Care		
17. Father's Name (First, Middle, Last) Juan (nmn) Garcia				18. Mother's Name (First, Middle, Maiden Surname) Edelmira (nmn) Lopez				
19a. Informant's Name/Relationship (Type, Print) Argelio Garcia / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13221 Falls Road, Hunt Valley, Maryland 21030				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		Date 10-18-00		20c. Location - City or Town, State Towson, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. myocardial infarction Due to (or as a consequence of): b. arteriosclerotic vascular disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number M48010		29d. Date signed (Month, Day, Year) 10/17/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR MICHAEL P. PHIN 9000 Franklin Square Drive Baltimore MD 21237								
31. Date filed (Month, Day, Year) OCT 18 2000		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Garcia, Argelio
Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #23A PER HY G789 11-13-00 WR.

Certificate of Death

Reg. No.

00 35913

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William John Greenert, Jr.				2. Date of Death Month Day Year June 23 2000				3. Time of Death 7:35 PM		
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare - Spa Creek Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 211-03-8738		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) May 9, 1920		9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent										
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 650 Americana Dr. # T7				10f. Zip Code 21403		10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1980		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Metalurgist				16b. Kind of Business/Industry U.S. Navy			
17. Father's Name (First, Middle, Last) William John Greenert				18. Mother's Name (First, Middle, Maiden Surname) Helen Claire Egan							
19a. Informant's Name/Relationship (Type, Print) Mary H. Greenert / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 650 Americana Dr. #T7 Annapolis, MD. 21403							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem.		Date 6-29-00		20c. Location - City or Town, State Crownsville, Md.			
21. Signature of Funeral Service Licensee C. Brian Russell				22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Seizure Due to (or as a consequence of): WERNICKE'S ENCEPHALOPATHY Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Wernicke's Encephalopathy										Approximate Interval Between Onset and Death 1 yr	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Wernicke's Encephalopathy										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier G. J. Sprane	
29c. License number D32036				29d. Date signed (Month, Day, Year) 6/24/2000							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gay J. Sprane 2108 D. Jones Drive Chester, MD 21619											
31. Date filed (Month, Day, Year) JUN 27 2000				32. Registrar's Signature B. Sprane							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35914

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RONALD

KENT

GUZIK

2. Date of Death

October 30, 2000

3. Time of Death

7:15 AM

4a. Facility Name (If not institution, give street and number)

Charlotte Hall Veterans' Home

4b. City, Town, or Location of Death

Charlotte Hall

4c. County of Death

St. Mary's

Funeral
Director

5. Social Security Number

055-26-3648

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 1, 1926

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Charlotte Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Route 2, Box 5

10f. Zip Code

20622

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Writer

16b. Kind of Business/Industry

Advertisement

17. Father's Name (First, Middle, Last)

Louis Guzik

18. Mother's Name (First, Middle, Maiden Surname)

Rose Edith Sadofsky

19a. Informant's Name/Relationship (Type, Print)

Ira Guzik/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

148 New Mark Esplanade, Rockville, Maryland 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans' Cem. 11-06-2000 Cheltenham, Maryland

Date

11-06-2000

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

MARK G. BROHAWN

M00053

22. Name and Address of Facility

The Hunt Funeral Home, Inc.

P.O. Box 156, Waldorf, Maryland 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. MASSIVE GASTROINTESTINAL BLEEDING

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ESOPHAGITIS, COLONIC POLYPS, DEMENTIA

PARKINSON'S, NORMAL PRESSURE HYDROCEPHALUS,

BRAIN TRAUMA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Fulton Lukran MD

29c. License number

D50963

29d. Date signed (Month, Day, Year)

10/30/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FULTON LUKRAN MD, CHAM 24449 CHARLOTTE HALL RD, CHARLOTTE HALL, MD 20622

31. Date filed (Month, Day, Year)

NOV 01 2000

32. Registrar's Signature

B. Sparks

State
Registrar

156, Walsby, A.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35915

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Betty J. Gaughan

2. Date of Death

Month Day Year
October 23, 2000

3. Time of Death

22:55

4a. Facility Name (If not institution, give street and number)

Lions Manor Nursing Home

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

218-50-0114

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
02-Jul-25

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Mount Savage

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15700 Mile Lane

10f. Zip Code

21545-

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

homemaker

17. Father's Name (First, Middle, Last)

Frank R. Brown

18. Mother's Name (First, Middle, Maiden Surname)

Edna Mae Mishler

19a. Informant's Name/Relationship (Type, Print)

Dick Gaughan son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12922 St. George's Lane Mt. Savage Maryland 21545-

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Saint Patrick's Parish Cemetery

Date

27-Oct-00

20c. Location - City or Town, State

Mount Savage, Maryland

21. Signature of Funeral Service Licensee

John R. Durst

22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Acute myocardial infarction
Due to (or as a consequence of):

40 minutes

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Coronary Artery Disease
Due to (or as a consequence of):

5 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus; History of Bilateral
Hemiparetic Infarct; History of chronic
obstructive Pulmonary Disease; Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Tan

29c. License number

D 21244

29d. Date signed (Month, Day, Year)

October 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Tan, M.D., Frostburg Plaza, Frostburg MD 21532

31. Date filed (Month, Day, Year)

OCT 25 2000

32. Registrar's Signature

J. Tan

State
RegistrarBetty Gaughan
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

3
ms

Page 1 of 1

Subject: [Illegible]

Date: [Illegible]

By: [Illegible]

Reference: [Illegible]

Location: [Illegible]

Time: [Illegible]

Witness: [Illegible]

Signature: [Illegible]

Print Name: [Illegible]

1200 W. 10th St.

City: [Illegible]

State: [Illegible]

Notes: [Illegible]

Investigation: [Illegible]

File: [Illegible]

Page: [Illegible]

Form 100-1 (Rev. 1-1-60)

Print Name: [Illegible]

Signature: [Illegible]

Witness: [Illegible]

Location: [Illegible]

Time: [Illegible]

Investigation: [Illegible]

[Handwritten signature]

[Handwritten signature]

Page 1 of 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

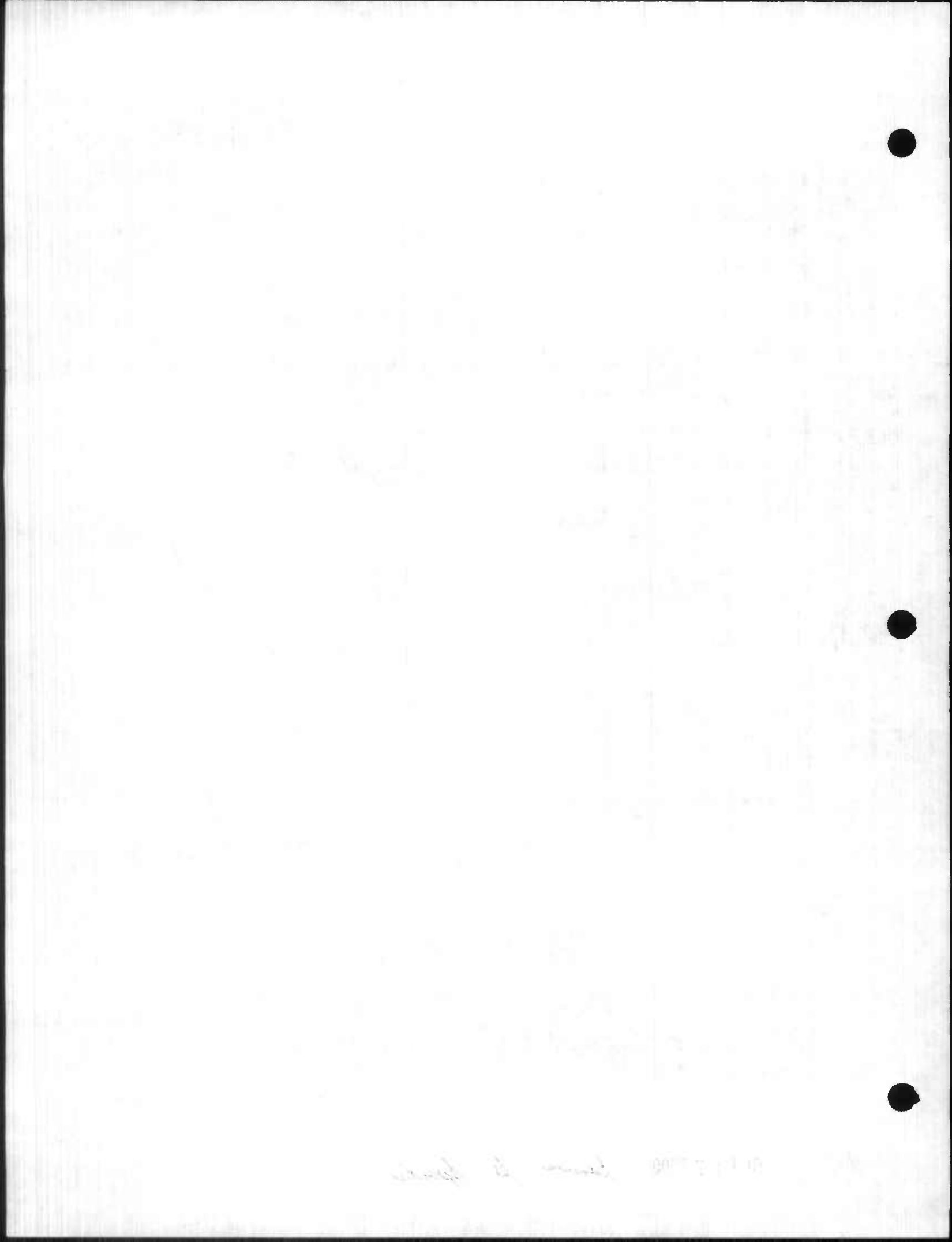
Reg. No.

00 35916

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BETTY JANE GRIGGS				2. Date of Death Month Day Year October 21, 2000		3. Time of Death 0315 a.m.		
	4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY		
Funeral Director	5. Social Security Number 214-28-4021		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 15 1925		
	9. Birthplace (State or Foreign Country) PA.		10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location WESTERNPORT		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 25701 SHADY LANE S.W.		10f. Zip Code 21562		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (1-4 or 5+) 3		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSE		16b. Kind of Business/Industry NURSE		17. Father's Name (First, Middle, Last) MELVIN CARTER		18. Mother's Name (First, Middle, Maiden Surname) Lillian Lawrence	
19a. Informant's Name/Relationship (Type, Print) BONNIE JUDY SISTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RFD#3 BOX#155 CLEARVILLE PA. 15535		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CUMBERLAND CREMATORY		20c. Location - City or Town, State OCTOBER 26 2000 CUMBERLAND MD.	
21. Signature of Funeral Service Licensee Dale L. Merritt		22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 8 days		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE Organic Brain Syndrome		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier S. Chang		29c. License number D25638		29d. Date signed (Month, Day, Year) October 21 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SATURNINA CHANG MD 10701 New George Creek S.W Suite 3 Frustking Maryland 21532		31. Date filed (Month, Day, Year) OCT 27 2000		32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35917

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NORMA JANE GARLAND

2. Date of Death

Month Day Year
OCTOBER 26 2000

3. Time of Death

9:35 AM

4a. Facility Name (If not Institution, give street and number)

Memorial Hospital & Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

218-16-3884

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG 25, 1924

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

LAVALE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1231 BRADDOCK ROAD

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

SUPERVISOR

16b. Kind of Business/Industry

COMMUNICATIONS

17. Father's Name (First, Middle, Last)

BOYD COLUMBUS RICE

18. Mother's Name (First, Middle, Maiden Surname)

GRACE ELIZABETH KNIPPENBERG

19a. Informant's Name/Relationship (Type, Print)

REV. LOWELL GARLAND-HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1231 BRADDOCK ROAD, LAVALE, MD 21502

20a. Method of Disposition

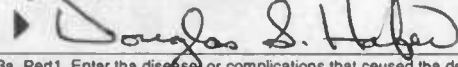
☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

HILLCREST MEMORIAL PARK

20c. Location - City or Town, State

CUMBERLAND, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HAVER CHAPEL OF THE HILLS MORTUARY
1302 NATIONAL HWY, LAVALE, MD 2150223a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Cardiac Arrhythmia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Hypertension and Hyperlipidemia

Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Approximate
Interval Between
Onset and Death

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Perforated Ileum due to radiation enteritis,cerebrovascular accident, postoperative pneumonia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury et
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

053158

29d. Date signed (Month, Day, Year)

OCTOBER 30, 2000

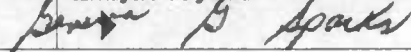
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. MICHAEL STASKO, 924 SETON DRIVE, CUMBERLAND, MARYLAND 21502

31. Date filed (Month, Day, Year)

NOV 01 2000

32. Registrar's Signature

State
Registrar

NORMA JANE GARLAND 218-16-3884

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10/3

ms

10/1/1914

1000 1000 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35918

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

WILLIAM FREDERICK HAYWARD

2. Date of Death

Month Day Year
October 26 2000

3. Time of Death

0340

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

213-22-7829

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 25 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5002 Bucktown Rd.

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

commercial waterman

16b. Kind of Business/Industry

seafood

17. Father's Name (First, Middle, Last)

Richard Burke Hayward

18. Mother's Name (First, Middle, Maiden Surname)

Millie Jones

19a. Informant's Name/Relationship (Type, Print)

Mary Lou Hayward - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5002 Bucktown Rd. Cambridge MD 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Dorchester Memorial Park

Date

10-28-00

20c. Location - City or Town, State

Cambridge, Maryland

21. Signature of Funeral Service Licensee

Kenneth R. Thomas Jr.

22. Name and Address of Facility

Thomas Funeral Home PA

700 Locust St. Cambridge MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

small cell lung cancer

Approximate
Interval Between
Onset and Death

12 mos.

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

liver metastases

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Craig W. Caldwell

29c. License number

D 33622

29d. Date signed (Month, Day, Year)

Oct. 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Craig W. Caldwell, MD 2 Aurora St. Cambridge MD 21613

31. Date filed (Month, Day, Year)

OCT 27 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35919

Amend item#1 HCHD 10-24-00 Certificate of Death BH

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Josephine Dorothy Hines

2. Date of Death

Month Day Year
October 20, 2000

3. Time of Death

10:15 A.M.

4a. Facility Name (If not institution, give street and number)

3206 Ravenwood Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-20-2078

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 26, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3206 Ravenwood Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

U. S. A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Meat Packer

16b. Kind of Business/Industry

Goetze's Meats

17. Father's Name (First, Middle, Last)

Anthony Dailey

18. Mother's Name (First, Middle, Maiden Surname)

Christina Merkle

19a. Informant's Name/Relationship (Type, Print)

Harry E. Hines (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4131 Shannon Drive, Baltimore, Maryland 21213

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

10/24/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

MARTIN Z...

22. Name and Address of Facility

Schmunek Funeral Home Inc.

3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Acute Myocardial Infarction

Due to (or as a consequence of):

CORONARY ARTERY DISEASE

Due to (or as a consequence of):

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Abdominal Aortic Aneurysm

Carotid Artery Disease

Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Miguel Karacuschansky

29c. License number

D0015462

29d. Date signed (Month, Day, Year)

10/20/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIGUEL KARACUSCHANSKY M.D., 200 E. 33rd St #640 BALTO. MD. 21218

State
Registrar

31. Date filed (Month, Day, Year)

OCT 24 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35920

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Inez Amelia Hansen				2. Date of Death Month Day Year Oct. 16 2000		3. Time of Death 0045	
	4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital				4b. City, Town, or Location of Death Havre de Grace		4c. County of Death Harford	
Funeral Director	5. Social Security Number 213-18-7221		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) 10/08/1921	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Harford		10c. City, Town or Location Aberdeen	
Usual Residence of Decedent								
10a. State MD			10b. County Harford			10c. City, Town or Location Aberdeen		
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			10e. Street and Number 41 East Bel Air Ave.			10f. Zip Code 21001		
10g. Citizen of What Country? USA			11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Home			17. Father's Name (First, Middle, Last) William Murphy		
18. Mother's Name (First, Middle, Maiden Surname) Nellie Digman			19a. Informant's Name/Relationship (Type, Print) Dean Hansen- Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 Sequoia Dr., Edgewood, MD 21040		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem.			20c. Location - City or Town, State 10/30/00 Arlington, VA		
21. Signature of Funeral Service Licensee Dwaine M. Smith			22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. coronary vascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day, Year) 10/16/00								
28b. Time of Injury M								
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier John J. Smith								
29c. License number 028339								
29d. Date signed (Month, Day, Year) October 17, 2000								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINPA FERGUSON 101 E. Wheel Road Bel Air MD 21015								
31. Date filed (Month, Day, Year) OCT 18 2000								
32. Registrar's Signature B. Smith								

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35921

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mable Laura Hilker

2. Date of Death

November 2, 2000

3. Time of Death

12:50 AM

4a. Facility Name (If not institution, give street and number)

Reeders Nursing Home

4b. City, Town, or Location of Death

Boonesboro

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

234-44-6474

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Feb. 10, 1907

9. Birthplace (State or Foreign Country)

Martinsburg, WV.

Usual Residence of Decedent

10a. State

WV.

10b. County

Jefferson

10c. City, Town or Location

Kearneysville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

411 Fox Glen

10f. Zip Code

25430

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Knitter

16b. Kind of Business/Industry

Innerwoven Mills

17. Father's Name (First, Middle, Last)

John Unger

18. Mother's Name (First, Middle, Maiden Surname)

Alice Heckrotte

19a. Informant's Name/Relationship (Type, Print)

Patricia Sanderson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

411 Fox Glen, Kearneysville, WV. 25430

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rosedale Cemetery

Date

11-2-00

20c. Location - City or Town, State

Martinsburg, WV.

21. Signature of Funeral Service Licensee

Larry H. Kime

22. Name and Address of Facility

Rosedale Funeral Chapel, Martinsburg, WV. 25401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *lower extremity arterial thrombus*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *probable sepsis*
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Diabetes**bladder cancer**breast cancer**multi infarct dementia*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William Hammerash

29c. License number

D 0055926

29d. Date signed (Month, Day, Year)

11/2/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. William Hammerash 100 Geeting Lane, Keedysville, Maryland 21756/301-432-2222

State
Registrar

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

*Geneva D. Sparks*Name: Mable L. Hilker
Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-535-2025.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35922

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOIS VERONICA HARDISON				2. Date of Death Month OCTOBER Day 31 , Year 2000		3. Time of Death 10:00 am	
	4a. Facility Name (If not institution, give street and number) Solomons Nursing Center				4b. City, Town, or Location of Death Solomons		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 240 14 8479		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) January 25 1917	
	9. Birthplace (State or Foreign Country) North Carolina		10a. State Maryland		10b. County Calvert		10c. City, Town or Location Lusby	
Usual Residence of Decedent								
10a. State Maryland			10b. County Calvert			10c. City, Town or Location Lusby		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			10e. Street and Number 1114 San Angelo Drive			10f. Zip Code 20657		
10g. Citizen of What Country? United States			11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker			16b. Kind of Business/Industry own home			17. Father's Name (First, Middle, Last) Edward Patrick Cunningham		
18. Mother's Name (First, Middle, Maiden Surname) Daisy Tyler			19a. Informant's Name/Relationship (Type, Print) R. Patrick Hardison - son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1114 San Angelo Drive Lusby, MD 20657		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			20c. Location - City or Town, State Nov 1 2000 Alexandria Virginia		
21. Signature of Funeral Service Licensee B. Rausch			22. Name and Address of Facility Rausch Funeral Home PA 4405 Briones Is. rd. Port Republic MD 20676			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CAD s/p CABG Due to (or as a consequence of): b. Acute Resp failure Due to (or as a consequence of): c. Uncontrolled DM Due to (or as a consequence of): d. Anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ch. Renal failure Severe COPD								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier D. Shah MD			29c. License number D 50290			29d. Date signed (Month, Day, Year) 10-31-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DHIREN SHAH 110, HOSP RD, #303 PRINCE FREDRICK MD 20678								
31. Date filed (Month, Day, Year) NOV 01 2000			32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35923

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EUGENE WILLIAM HARMON				2. Date of Death Month Day Year OCTOBER 29, 2000		3. Time of Death 21:22	
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital				4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 331 12 4028	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Apr. 13, 1922	9. Birthplace (State or Foreign Country) Illinois	
	Usual Residence of Decedent							
10a. State Maryland		10b. County Calvert		10c. City, Town or Location Owings			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 1221 Barefoot Lane				10f. Zip Code 20736		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) bricklayer & carpenter		16b. Kind of Business/Industry construction		
17. Father's Name (First, Middle, Last) John Harmon				18. Mother's Name (First, Middle, Maiden Surname) Margarette unknown				
19a. Informant's Name/Relationship (Type, Print) Greg S. Harmon / son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as # 10 above				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Caldonia Cemetery		Date 11-04-00		20c. Location - City or Town, State Knoxville, TN		
21. Signature of Funeral Service Licensee William B. [Signature]				22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. VENTRICULAR ARRHYTHMIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Peter [Signature]		29c. License number D40370		29d. Date signed (Month, Day, Year) 10/30/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. PETER WISNIEWSKI, M.D. PRINCE FREDERICK, MD 20678								
31. Date filed (Month, Day, Year) NOV 01 2000		32. Registrar's Signature Benita B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35924

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Martha

Hayes

2. Date of Death

Month
Nov.Day
2,Year
2000

3. Time of Death

10:50P.

4a. Facility Name (If not institution, give street and number)

505 Deerfield Avenue

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

217-48-9249

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

Nov. 24, 1953

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

505 Deerfield Avenue

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Hydrologist

16b. Kind of Business/Industry

United States

Geological Survey

17. Father's Name (First, Middle, Last)

Robert C. Hayes

18. Mother's Name (First, Middle, Maiden Surname)

Grace Person

19a. Informant's Name/Relationship (Type, Print)

James (Jim) Lewis - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Congressional Cemetery 11/6/2000

Date

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service licensee

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.

4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Metastatic Breast Cancer* Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D33293

29d. Date signed (Month, Day, Year)

November 3, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick Smith, M.D. 5401 Western Avenue, N.W. Washington, D.C. 20015

State
Registrar

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #26 PER PHY G789 11-18-00 WR.

Certificate of Death

Reg. No.

00 35925

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Everett Hyde				2. Date of Death Month Day Year October 17, 2000		3. Time of Death 1:42 P.M.		
	4a. Facility Name (If not institution, give street and number) 925 Hunting Lake Drive				4b. City, Town, or Location of Death Huntingtown		4c. County of Death Calvert Co.		
Funeral Director	5. Social Security Number 216-40-5172		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 26, 1942		
	9. Birthplace (State or Foreign Country) Washington DC		10a. State MD		10b. County Calvert Co.		10c. City, Town or Location Huntingtown		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 925 Hunting Lake Drive		10f. Zip Code 20639		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Foreman		16b. Kind of Business/Industry Union Carpenter		17. Father's Name (First, Middle, Last) William B. Hyde		18. Mother's Name (First, Middle, Maiden Surname) Gladys M. Gibbs Martin	
19a. Informant's Name/Relationship (Type, Print) Judy Lee Hyde (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 925 Hunting Lake Dr. Huntingtown, MD 20639		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory		20c. Location - City or Town, State Clinton, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Glioblastoma Multiforme (Brain) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D33123		29d. Date signed (Month, Day, Year) 10-18-00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan D. Lowenthal, M.D. 110 Hospital Rd. 310 Prince Frederick, MD 20678		31. Date filed (Month, Day, Year) OCT 18 2000		32. Registrar's Signature 					

January 2, 1901

Dear

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35926

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CAROL LOUISE HALL			2. Date of Death Month OCT Day 22 Year 2000		3. Time of Death 2 13 PM	
	4a. Facility Name (If not institution, give street and number) 9617 MEADOW LARK AVE			4b. City, Town, or Location of Death UPPER MARLBORO		4c. County of Death PRINCE GEORGE	
Funeral Director	5. Social Security Number 217-64-9971		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 46 Yrs.		8. Date of Birth (Month, Day, Year) October 28, 1953
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Upper Marlboro
Usual Residence of Decedent							
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number 9617 Meadow Lark Avenue							
10f. Zip Code 20772							
10g. Citizen of What Country? U S A							
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced							
12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:							
14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+)							
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assistant Manager							
16b. Kind of Business/Industry Retail Shoe Store							
17. Father's Name (First, Middle, Last) James Merle Stanley Hall							
18. Mother's Name (First, Middle, Maiden Surname) Mary Louise Walker							
19a. Informant's Name/Relationship (Type, Print) Mary L. Gibson (Mother)							
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Gentry Court, Bryans Road, Maryland 20616							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)							
20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart Cemetery							
20c. Date 10/26/2000							
20d. Location - City or Town, State Bushwood, Maryland							
21. Signature of Funeral Service Licensee Michael Gardiner							
22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic lung cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Approximate Interval Between Onset and Death 11 mos							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined							
28a. Date of Injury (Month, Day, Year)							
28b. Time of Injury M							
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No							
28d. Describe how injury occurred							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier [Signature]							
29c. License number D-17605							
29d. Date signed (Month, Day, Year) 10/23/00							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. J. VAIDAK MD Clinton, MD							
31. Date filed (Month, Day, Year) OCT 23 2000							
32. Registrar's Signature [Signature]							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35927

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Jamison				2. Date of Death Month October Day 19 Year 2000				3. Time of Death 10:40 pm	
	4a. Facility Name (If not institution, give street and number) Citizens Nursing Home				4b. City, Town, or Location of Death Harford				4c. County of Death Harford	
Funeral Director	5. Social Security Number 579-12-2335		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 22, 1914		9. Birthplace (State or Foreign Country) U.S.A. Maryland	
	Usual Residence of Decedent									
10a. State MD		10b. County Harford		10c. City, Town or Location Aberdeen				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 340 Mount Royal Avenue				10f. Zip Code 21001				10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver				16b. Kind of Business/Industry Driver		
17. Father's Name (First, Middle, Last) John Jamison				18. Mother's Name (First, Middle, Maiden Surname) Hattie Sutton						
19a. Informant's Name/Relationship (Type, Print) Florence Stanchel (niece)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 340 Mt. Royal Ave. Aberdeen, MD 21001						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Grove Presbyterian		20c. Date 10/24/00		20d. Location - City or Town, State Aberdeen, Maryland				
21. Signature of Funeral Service Licensee Husken Duffin				22. Name and Address of Facility Tanning-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Coronary Artery disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death > 10 yrs.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHF. Hypertension										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier W. T. W. M.D.		29c. License number D32609		29d. Date signed (Month, Day, Year) 10/20/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kamrudin Metham MD 1106 Revolution St Harford MD 21078										
31. Date filed (Month, Day, Year) OCT 23 2000		32. Registrar's Signature B. Spade								

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35928

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Andre Jones</u>				2. Date of Death Month <u>10</u> Day <u>24</u> Year <u>2000</u>				3. Time of Death <u>11:54 am</u>		
	4e. Facility Name (If not institution, give street and number) <u>Univ. of Md Medical System</u>				4b. City, Town, or Location of Death <u>Univ. of Md.</u>				4c. County of Death <u>Baltimore City</u>		
Funeral Director	5. Social Security Number <u>217-19-1932</u>		6. Sex <u>1</u> M <u>2</u> F		7. Age (In yrs. last birthday) <u>21</u> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) <u>Dec. 18, 1978</u>		9. Birthplace (State or Foreign Country) <u>Washington, D.C.</u>		10a. State <u>Maryland</u>		10b. County <u>Calvert</u>		10c. City, Town or Location <u>Huntingtown</u>		
To Be Completed by Funeral Director	10a. Street and Number <u>2079 Plum Point Road</u>		10f. Zip Code <u>20639</u>		10g. Citizen of What Country? <u>USA</u>		10d. Inside City Limits <u>1</u> Yes <u>2</u> No				
	11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Student</u>		16b. Kind of Business/Industry <u>Technical School</u>						
	17. Father's Name (First, Middle, Last) <u>Wesley R. Jones, Jr.</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Rose Marie Fenwick</u>						
	19a. Informant's Name/Relationship (Type, Print) <u>Rose M. Fenwick/Mother</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>48632 St. James Church Rd. Lexington Park, MD 20653</u>						
	20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Youngs Cemetery</u>		Date <u>10/31/00</u>		20c. Location - City or Town, State <u>Huntingtown, MD</u>				
	21. Signature of Funeral Service Licensee <u>Robert A. Fenton</u>				22. Name and Address of Facility <u>Sewell Funeral Home</u> <u>1451 Dares Beach Rd. Prince Frederick, MD 20678</u>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. Cardiac arrest</u> Due to (or as a consequence of): <u>b. Pulmonary embolus (presumed)</u> Due to (or as a consequence of): <u>c. Lymphoblastic lymphoma</u> Due to (or as a consequence of): <u>d. Pneumonia</u>				Approximate interval between Onset and Death <u>45 minutes</u>						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Greater than 30 days of bone marrow aplasia secondary to chemotherapy.</u>				23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown						
	25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No		28. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>8</u> Other (Specify)		27. Manner of Death <u>1</u> Natural <u>5</u> Pending investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide		28a. Date of Injury (Month, Day Year) <u></u>		28b. Time of Injury <u>M</u>		28c. Injury at Work? <u>1</u> Yes <u>2</u> No
29a. Certifier (Check only one) <u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>Robert A. Fenton MD</u>		29c. License number <u>D0038578</u>		29d. Date signed (Month, Day, Year) <u>10/24/00</u>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Robert A. Fenton 22 South Greene St., Baltimore, Maryland 20001</u>		31. Date filed (Month, Day, Year) <u>OCT 30 2000</u>		32. Registrar's Signature <u>Benjamin S. Sparks</u>							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 16 Rev 6/95

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 35929

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jan James Kitlowski				2. Date of Death Month Day Year October 25, 2000				3. Time of Death 2:25 AM	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 163-34-0965		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Jan. 22, 1940		9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Harford		10c. City, Town or Location Churchville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 310 Middleton Court		10f. Zip Code 21028		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager		16b. Kind of Business/Industry Retail Department Store					
	17. Father's Name (First, Middle, Last) Henry Felix Kitlowski				18. Mother's Name (First, Middle, Maiden Surname) Mildred Dolores Schuh					
	19a. Informant's Name/Relationship (Type, Print) Jean Ann Kitlowski/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Middleton Court, Churchville, MD 21028					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gardens		20c. Location - City or Town, State 10-28-00 Bel Air, Maryland					
	21. Signature of Funeral Service Licensee Charles A. Emge Jr.		22. Name and Address of Facility McComas Funeral Home, P.A. 50 West Broadway Street, Bel Air, MD 21014							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Prostate Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 3 years	
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) Hospice							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Anthony Riley, MD		29c. License number D 25005		29d. Date signed (Month, Day, Year) October 25, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. Riley, 6701 N. Charles St. Balto. md 21204									
State Registrar	31. Date filed (Month, Day, Year) OCT 26 2000		32. Registrar's Signature B. Sparks							

ORIGINAL

100-2-8 TCO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35930

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Valerie Anne Keating

2. Date of Death
Month Day Year
October 17, 2000

3. Time of Death
3:30 AM

4a. Facility Name (If not institution, give street and number)

2803 Brockway Place

4b. City, Town, or Location of Death

Kingsville

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

057-32-4764

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 25, 1937

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Kingsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2803 Brockway Place

10f. Zip Code

21087

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Vincent Quinlan

18. Mother's Name (First, Middle, Maiden Surname)

Anne Marie Flinn

19a. Informant's Name/Relationship (Type, Print)

Bruce C. Keating - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2803 Brockway Place, Kingsville, MD 21087

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Highview Memorial Grdns.

Date

10/20/00

20c. Location - City or Town, State

Fallston, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Rd., Abingdon, MD 21009

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Breast Cancer

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier

Dr. [Signature] MD

29c. License number

D40854

29d. Date signed (Month, Day, Year)

10/17/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Ruseberg, MD 301 St Paul Pl Baltimore 21202

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at 202-695-3028.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

jhm
LINDA JOYCE
KAROLL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35931

amend item 23a, b, pt II, 27, 28a, b, c, d, e, f per me G790 12

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LINDA J. KAROLL			2. Date of Death Month Day Year NOVEMBER 05, 2000		3. Time of Death 13:11 PM			
	4a. Facility Name (If not institution, give street and number) UPPER CHESAPEAKE MEDICAL CENTER			4b. City, Town, or Location of Death Bel Air		4c. County of Death HARFORD			
Funeral Director	5. Social Security Number 215-60-4143		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1/20/1953	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
10a. State PA		10b. County York		10c. City, Town or Location Delta		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 221 Bair Road				10f. Zip Code 17314		10g. Citizen of What Country? United States			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry Electric Utility			
17. Father's Name (First, Middle, Last) Harry E. Uphoff				18. Mother's Name (First, Middle, Maiden Surname) Cecelia Whittington					
19a. Informant's Name/Relationship (Type, Print) Jennifer L. Karoll				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 Bair Road, Delta, PA 17314					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Eagle Crematory		Date 11/7		20c. Location - City or Town, State Leola, PA			
21. Signature of Funeral Service Licensee <i>Jeffrey P. Lovelace</i>				22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHOKED ON A BOLUS OF FOOD Due to (or as a consequence of): b. MULTIPLE SCLEROSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. FOCAL ASPIRATION PNEUMONIA						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 11/5/00		28b. Time of Injury Approximately 12:10 P		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject choked on food	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) group home				28f. Location (Street and Number or Rural Route Number, City or Town, State) 194 Kilgore Road, Delta, Pennsylvania 17314			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Stephen S. Radentz, M.D.</i>		29c. License number OCME		29d. Date signed (Month, Day, Year) NOVEMBER 06, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature <i>Sparks</i>							

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

Amended #s 196, 26, nls,
10/23/00, Allsigning Co,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 35932

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ERMA LEONA KNISELEY				2. Date of Death Month Day Year OCTOBER 19, 2000				3. Time of Death 7:15 AM	
	4a. Facility Name (If not institution, give street and number) 100 VILLAGE PARK WAY				4b. City, Town, or Location of Death FROSTBURG				4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 213-50-6022		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		8. Date of Birth (Month, Day, Year) SEPT. 29, 1904		9. Birthplace (State or Foreign Country) PENNSYLVANIA	
	Usual Residence of Decedent									
10a. State MD		10b. County ALLEGANY		10c. City, Town or Location RAWLINGS				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 16100 RAWLINGS HEIGHTS DRIVE, SW				10f. Zip Code 21557				10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry HOME		
17. Father's Name (First, Middle, Last) JOHN LOUIS GERHART				18. Mother's Name (First, Middle, Maiden Surname) ANNA LOHR						
19a. Informant's Name/Relationship (Type, Print) JOYCE SMITH/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16100 RAWLINGS HEIGHTS DR., SW, RAWLINGS, MD 21557						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ZION MEMORIAL PARK		20c. Location - City or Town, State 10/21/2000 CUMBERLAND, MD						
21. Signature of Funeral Service Licensee <i>Shirley A. Upchurch</i>				22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>CORONARY ARTERY DISEASE</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 3 YRS								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Assisted Living								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>Robustiano J. Barrera</i>				29c. License number D-14865		29d. Date signed (Month, Day, Year) OCT. 20, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBUSTIANO J. BARRERA, M.D. - 500 MEMORIAL AVE., CUMBERLAND, MD 21502										
31. Date filed (Month, Day, Year) OCT 23 2000				32. Registrar's Signature <i>Barrera B Sparks</i>						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35933

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Cecil Darl Kerns				2. Date of Death Month Day Year Oct 21, 2000		3. Time of Death 09:45pm	
	4a. Facility Name (If not institution, give street and number) 22802 Oldtown Road SE				4b. City, Town, or Location of Death Oldtown		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 721-18-9814	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	8. Date of Birth (Month, Day, Year) Sep 17, 1924	9. Birthplace (State or Foreign Country) MD			
	Usual Residence of Decedent							
10a. State MD		10b. County Allegany		10c. City, Town or Location Oldtown		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 22802 Oldtown Road SE.				10f. Zip Code 21555		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) Trackman				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chessie System RR		16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) John F. Kerns				18. Mother's Name (First, Middle, Maiden Surname) Dessie M (Rice)				
19a. Informant's Name/Relationship (Type, Print) Shirley M. Kerns Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22802 Oldtown Road SE; Oldtown, MD 21555				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Davis Memorial Cemetery		20c. Location - City or Town, State 2000 Cumberland, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Scarpelli Funeral Home P.A. Cumberland, Maryland 21502				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Heart Disease Due to (or as a consequence of): b. Diabetes Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death unk years	
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D09157		29d. Date signed (Month, Day, Year) Oct 22, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Snow M.D. 124 W. 3rd Street Cumberland MD 21502								
31. Date filed (Month, Day, Year) OCT 23 2000				32. Registrar's Signature 				

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35934

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alice Julia Koch

2. Date of Death

Month Day Year
Oct 22, 2000

3. Time of Death

08:30am

4a. Facility Name (If not institution, give street and number)

220 Arch Street

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

217-10-7948

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan 23, 1907

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

220 Arch Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Robert Kelley

18. Mother's Name (First, Middle, Maiden Surname)

Alice J (Bowser)

19a. Informant's Name/Relationship (Type, Print)

Melissa E. Mullis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1424 Magnolia Court; Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Sunset Memorial Park

Date

10/24

20c. Location - City or Town, State

2000 Cumberland, MD

21. Signature of Funeral Service Licensee

James F. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home P.A.
Cumberland, Maryland 2150223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. lung cancer
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

3 mn

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Anthony Bollino M.D.

29c. License number

D17565

29d. Date signed (Month, Day, Year)

Oct 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony Bollino M.D. 922 National Highway LaVale MD 21502

State
Registrar

31. Date filed (Month, Day, Year)

Oct 24 2000

32. Registrar's Signature

James F. Scarpelli

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
20254.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

M.D.

Handwritten text, possibly a signature or date, located at the bottom center of the page.

1000 P. 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35935

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Melvin Kidwell, Sr.

2. Date of Death

Month Day Year
October 30, 2000

3. Time of Death

5:40 AM

4a. Facility Name (If not institution, give street and number)

315 W. Chesapeake Beach Road

4b. City, Town, or Location of Death

Owings

4c. County of Death

Anne Arundel Co.

Funeral
Director

5. Social Security Number

579-32-2052

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Nov. 19, 1923

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel Co.

10c. City, Town or Location

Owings

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

315 W. Chesapeake Beach Road

10f. Zip Code

20736

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Tax Revenue Enforcement Officer

16b. Kind of Business/Industry

District of Columbia Government

17. Father's Name (First, Middle, Last)

George H. Kidwell, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Edith Mae Rush

19a. Informant's Name/Relationship (Type, Print)

Virginia C. Kidwell (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

315 W. Chesapeake Beach Rd., Owings, MD 20736

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee Crematory

Date

Oct., 31, 2000

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee Funeral Home Calvert, P.A.

8125 Southern Maryland Blvd. Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Arteriosclerotic

Due to (or as a consequence of):

b. Cardiovascular Disease

Due to (or as a consequence of):

c. Chronic Essential Hypertension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☒ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D12705

29d. Date signed (Month, Day, Year)

October 31, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Emad R. Al-Banna 1050 Solomons Island Rd. Prince Frederick, MD 20678

31. Date filed (Month, Day, Year)

NOV 01 2000

32. Registrar's Signature

Benita Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

00 35936

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PAUL EVERETT LEES		2. Date of Death Month Day Year OCTOBER 31, 2000		3. Time of Death 12:14 AM
	4a. Facility Name (If not institution, give street and number) CIVISTA MEDICAL CENTER		4b. City, Town, or Location of Death LAPLATA		4c. County of Death CHARLES
Funeral Director	5. Social Security Number 495-30-2624	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (in yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 6, 1930
	9. Birthplace (State or Foreign Country) Missouri				
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State Maryland	10b. County Charles	10c. City, Town or Location Waldorf		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 2278 Ingleside Court		10f. Zip Code 20603		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Korean If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
To Be Completed by Physician/Medical Examiner	14. Race - American Indian, Black, White, etc. White Specify:				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Meteorologist		16b. Kind of Business/Industry U. S. Government
	17. Father's Name (First, Middle, Last) Charles William Lees		18. Mother's Name (First, Middle, Maiden Surname) Catherine Mayo		
	19a. Informant's Name/Relationship (Type, Print) Helen Lees/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2278 Ingleside Court, Waldorf, Maryland 20603		
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) Huntt Crematory		20c. Location - City or Town, State 11-01-2000 Waldorf, Maryland
	21. Signature of Funeral Service Licensee MARK G. BROHAWN MO0053		22. Name and Address of Facility The Huntt Funeral Home, Inc. P.O. Box 156, Waldorf, Maryland		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	Immediate Cause (Final disease or condition resulting in death) a. METASTATIC CARCINOMA OF COLON Due to (or as a consequence of): b. END STAGE RENAL FAILURE Due to (or as a consequence of): c. HISTORY OF HYPERTENSION Due to (or as a consequence of): d.				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEIZURE DISORDER					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Kevin Lee					
29c. License number D-054804					
29d. Date signed (Month, Day, Year) 10/31/00					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEVIN K. LEE M.D. 7-C POST OFFICE ROAD CENNA CENTER WALDORF MD. 20602					
31. Date filed (Month, Day, Year) NOV 01 2000					
32. Registrar's Signature B. Smith					

ORIGINAL

2001-11-11

Page 1 of 1

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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #1 PER PHY G789 11-8-00 WR.

Certificate of Death

Reg. No.

00 35937

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>FREDERICK JOHN LOTTI</u>		2. Date of Death Month <u>September</u> Day <u>5</u> Year <u>2000</u>		3. Time of Death <u>2257</u>
	4a. Facility Name (If not institution, give street and number) <u>The Johns Hopkins Hospital</u>		4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death <u>Baltimore</u>
Funeral Director	5. Social Security Number <u>187-34-4956</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birth day) <u>56</u> Yrs.	8. Date of Birth (Month, Day, Year) <u>Aug. 18, 1944</u>	9. Birthplace (State or Foreign Country) <u>Pennsylvania</u>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <u>Maryland</u>	10b. County <u>St. Mary's</u>	10c. City, Town or Location <u>California</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10a. Street and Number <u>44110 Louisdale Road</u>		10f. Zip Code <u>20619</u>		10g. Citizen of What Country? <u>United States</u>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6</u> College (1-4 or 5+) <u>6</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Supervisor Engineer</u>		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>
	17. Father's Name (First, Middle, Last) <u>Anselmo Lotti</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Marie Hanek</u>		16b. Kind of Business/Industry <u>Civil Service</u>
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>Susan Lotti</u> <u>Wife</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>44110 Louisdale Road, California, Maryland 20619</u>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Charles Memorial Gardens</u>		20c. Location - City or Town, State <u>Leonardtown, Maryland</u>
	21. Signature of Funeral Service Licensee <u>Edward N. Brinsfield, Jr.</u> M00052		22. Name and Address of Facility <u>Brinsfield Funeral Home, P.A.</u> <u>22955 Hollywood Road, Leonardtown, Maryland 20650</u>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. Sepsis</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <u>b. End-stage liver disease</u> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <u>M</u>		28b. Time of Injury <u>1</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <u>D. J. [Signature]</u> M.D.		29c. License number <u>RES-000</u>		29d. Date signed (Month, Day, Year) <u>September 5, 2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Derek Taylor 600 N. Wolfe Street, Baltimore, Maryland 21287</u>					
31. Date filed (Month, Day, Year) <u>SEP 08 2000</u>		32. Registrar's Signature <u>[Signature]</u>			

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35938

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY DOROTHY LAMBERT

2. Date of Death
Month Day Year

OCT. 24, 2000

3. Time of Death

6:20 PM

4a. Facility Name (If not institution, give street and number)

WESTMINSTER NURSING HOME

4b. City, Town, or Location of Death

WESTMINSTER

4c. County of Death

CARROLL

5. Social Security Number

213-05-1673

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

4/14/1910

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

CARROLL

10c. City, Town or Location

WESTMINSTER

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

24 W. GEORGE ST.

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

MACHINE OPERATOR

16b. Kind of Business/Industry

MANUFACTURING

17. Father's Name (First, Middle, Last)

JAMES H. SWARTZBAUGH

18. Mother's Name (First, Middle, Maiden Surname)

MYRTLE OWINGS

19a. Informant's Name/Relationship (Type, Print)

PEGGY J. STULTZ - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

414 LONDON CT., WESTMINSTER, MD. 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

EVERGREEN MEM. GARDENS 10/28/00 FINKSBURG, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility FLETCHER FUNERAL HOME

254 E. MAIN ST., WESTMINSTER, MD. 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cerebral Vascular Accident

Approximate Interval Between Onset and Death

2 wks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D32882

29d. Date signed (Month, Day, Year)

10/25/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert L. Moss 114 Business Center Dr. Reisterstown, MD 21136

31. Date filed (Month, Day, Year)

OCT 26 2000

32. Registrar's Signature

State

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35939

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Rachel Grace Logsdon</i>				2. Date of Death Month <i>October</i> Day <i>17</i> , Year <i>2000</i>				3. Time of Death <i>9:35 A.M.</i>	
	4a. Facility Name (If not institution, give street and number) <i>Memorial Hospital & Medical Center</i>				4b. City, Town, or Location of Death <i>Cumberland</i>				4c. County of Death <i>Allegany</i>	
Funeral Director	5. Social Security Number <i>161 16 5419</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>83</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>8-2-1917</i>		9. Birthplace (State or Foreign Country) <i>PA</i>	
	10a. State <i>PA</i>				10b. County <i>Bedford</i>		10c. City, Town or Location <i>Hyndman</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>301 Schellsburg Street</i>										
10f. Zip Code <i>15545</i>										
10g. Citizen of What Country? <i>USA</i>										
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>				16b. Kind of Business/Industry <i>Home</i>		
17. Father's Name (First, Middle, Last) <i>W. Stanley Pensyl</i>						18. Mother's Name (First, Middle, Maiden Summa) <i>Minnie Belle Aberle</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Robert C. Logsdon, Son</i>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>527 S. Kimberly Ave. Somerset, PA 15501</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Hyndman Cemetery</i>		Date <i>10-21-00</i>		20c. Location - City or Town, State <i>Hyndman, PA 15545</i>		
21. Signature of Funeral Service Licensee <i>Harvey H. Zeigler</i>						22. Name and Address of Facility <i>Harvey H. Zeigler Funeral Home, Hyndman, PA</i>				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>CHRONIC RENAL FAILURE</i> Due to (or as a consequence of): b. <i>INSULIN-DEPENDENT DIABETES MELLITUS</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Approximate Interval Between Onset and Death <i>2 YEARS</i> <i>> 5 YEARS</i>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Terry E. Williams MD</i>						29c. License number <i>D16041</i>		29d. Date signed (Month, Day, Year) <i>October 17, 2000</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dr. Terry E. Williams 500 Memorial Avenue, Cumberland, MD 21502</i>										
31. Date filed (Month, Day, Year) <i>OCT 19 2000</i>						32. Registrar's Signature <i>Sparks</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Spencer H. [unclear]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35940

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elmer Coolidge Lashley					2. Date of Death Month Day Year October 17, 2000		3. Time of Death 7:20 A.M.																						
	4a. Facility Name (If not institution, give street and number) Memorial Hospital & Medical Center					4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany																						
Funeral Director	5. Social Security Number 215-26-9246		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 20, 1924		9. Birthplace (State or Foreign Country) MD																					
	Usual Residence of Decedent																													
10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																						
10a. Street and Number 641 Shriver Ave.					10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.																							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Date 15 Nov 43		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White																						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pipefitter/Sheet Metal			16b. Kind of Business/Industry Railroad																						
17. Father's Name (First, Middle, Last) Benjamin Lashley					18. Mother's Name (First, Middle, Maiden Surname) Lillie Norris																									
19a. Informant's Name/Relationship (Type, Print) Shirley E. Lashley (wife)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 641 Shriver Ave. Cumberland, MD 21502																									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem. at Rocky Gap			20c. Location - City or Town, State 10/20/00 Flintstone, MD																								
21. Signature of Funeral Service Licensee Dale L. Merritt					22. Name and Address of Facility Merritt-Adams Funeral Home, P.A. 404 Decatur St. Cumberland, MD 21502																									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																														
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Sepsis</td> <td>Approximate Interval Between Onset and Death 4 weeks</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>Peripheral Vascular Disease</td> <td>X 2 Years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Sepsis	Approximate Interval Between Onset and Death 4 weeks	Due to (or as a consequence of):			b.	Peripheral Vascular Disease	X 2 Years	Due to (or as a consequence of):			c.	Due to (or as a consequence of):			d.	Due to (or as a consequence of):		
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Sepsis	Approximate Interval Between Onset and Death 4 weeks																											
	Due to (or as a consequence of):																													
	b.	Peripheral Vascular Disease	X 2 Years																											
	Due to (or as a consequence of):																													
c.	Due to (or as a consequence of):																													
d.	Due to (or as a consequence of):																													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																						
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																						
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																					
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																														
29b. Signature and title of certifier [Signature]					29c. License number D 0023371		29d. Date signed (Month, Day, Year) October 19, 2000																							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Qamar Zaman 625 Kent Ave. Johnson Heights Medical Bldg., Cumberland, MD																														
31. Date filed (Month, Day, Year) Oct 24 2000					32. Registrar's Signature [Signature]																									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

9

ms

State
Registrar

copy to [unclear] 4/12/10

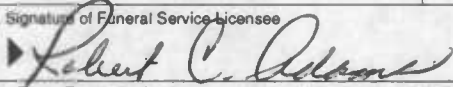
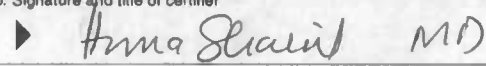

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35941

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bonnie Jean Linn		2. Date of Death Month Day Year 10-24-2000		3. Time of Death 11:40a.m.												
	4a. Facility Name (If not institution, give street and number) Memorial Hospital & Medical Center		4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany												
Funeral Director	5. Social Security Number 219-46-0552	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	8. Date of Birth (Month, Day, Year) October 11, 1947	9. Birthplace (State or Foreign Country) MD												
	Usual Residence of Decedent																
To Be Completed by Funeral Director	10a. State MD	10b. County Allegany	10c. City, Town or Location Mt. Savage		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
	10e. Street and Number 12514 Woodcock Hollow Road		10f. Zip Code 21545		10g. Citizen of What Country? U.S.A.												
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:												
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress												
	16b. Kind of Business/Industry Food		17. Father's Name (First, Middle, Last) William Self		18. Mother's Name (First, Middle, Maiden Surname) Nannie Riggleman												
	19a. Informant's Name/Relationship (Type, Print) Ronald A. Linn (Husband)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12514 Woodcock Hollow Road Mt. Savage, MD 21545														
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) The Cumberland Crematory		20c. Location - City or Town, State Cumberland, MD												
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Merritt-Adams Funeral Home, P.A. 404 Decatur St. Cumberland, MD 21502														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Sepsis</td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 3 Weeks</td> </tr> <tr> <td>b. Respiratory Failure</td> <td>Due to (or as a consequence of):</td> <td>2 Years</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>					Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 3 Weeks	b. Respiratory Failure	Due to (or as a consequence of):	2 Years	c.	Due to (or as a consequence of):		d.	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 3 Weeks														
	b. Respiratory Failure	Due to (or as a consequence of):	2 Years														
	c.	Due to (or as a consequence of):															
	d.	Due to (or as a consequence of):															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple Sclerosis, Chronic Obstructive Pulmonary Disease, Decubitus Ulcer																	
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																	
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined																	
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																	
28d. Describe how injury occurred																	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																	
28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
29b. Signature and title of certifier  MD																	
29c. License number D46346																	
29d. Date signed (Month, Day, Year) 10-25-2000																	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shakil, Huma, M.D. Johnson Heights Medical Bldg., Cumberland, Maryland 21502																	
31. Date filed (Month, Day, Year) OCT 25 2000																	
32. Registrar's Signature 																	

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ADMEND ITEM: #14 PER F.H. G792 4-17-01 WR

AMEND ITEM: #9 PER F.H. G792 2-5-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35942

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jean William LaFond				2. Date of Death Month Day Year October 3, 2000		3. Time of Death 6:45pm	
	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital				4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 216-53-0420	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 42 Yrs.	8. Under 1 Year Months Days	8. Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 13, 1957		9. Birthplace (State or Foreign Country) Haiti BLACK
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Beltsville		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 11506 Allview DR.				10f. Zip Code 20705		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. BLACK Specify: Haitian		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Engineer		16b. Kind of Business/Industry Private		
17. Father's Name (First, Middle, Last) Gilbert LaFond				18. Mother's Name (First, Middle, Maiden Surname) Anne Mariella Robert				
19a. Informant's Name/Relationship (Type, Print) Marie M. LaFond / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11506 Allview Dr. Beltsville, Md. 20705				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. Date 10/9/00		20d. Location - City or Town, State Beltsville, Md.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747				
23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. Cardiac Arrhythmia Due to (or as a consequence of):					Approximate Interval Between Onset and Death Days	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):						
		c. Due to (or as a consequence of):						
		d. Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D41715		29d. Date signed (Month, Day, Year) October 4, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chitra Venkatraman, M.D. 6201 Greenbelt Rd. College Park, Md. 20740								
State Registrar	31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ADMEND ITEM: #26 PER PHY G793 3-21-01 WR. **Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

AMEND ITEM: 26 PER HY G789 11-29-00 WR.

Certificate of Death

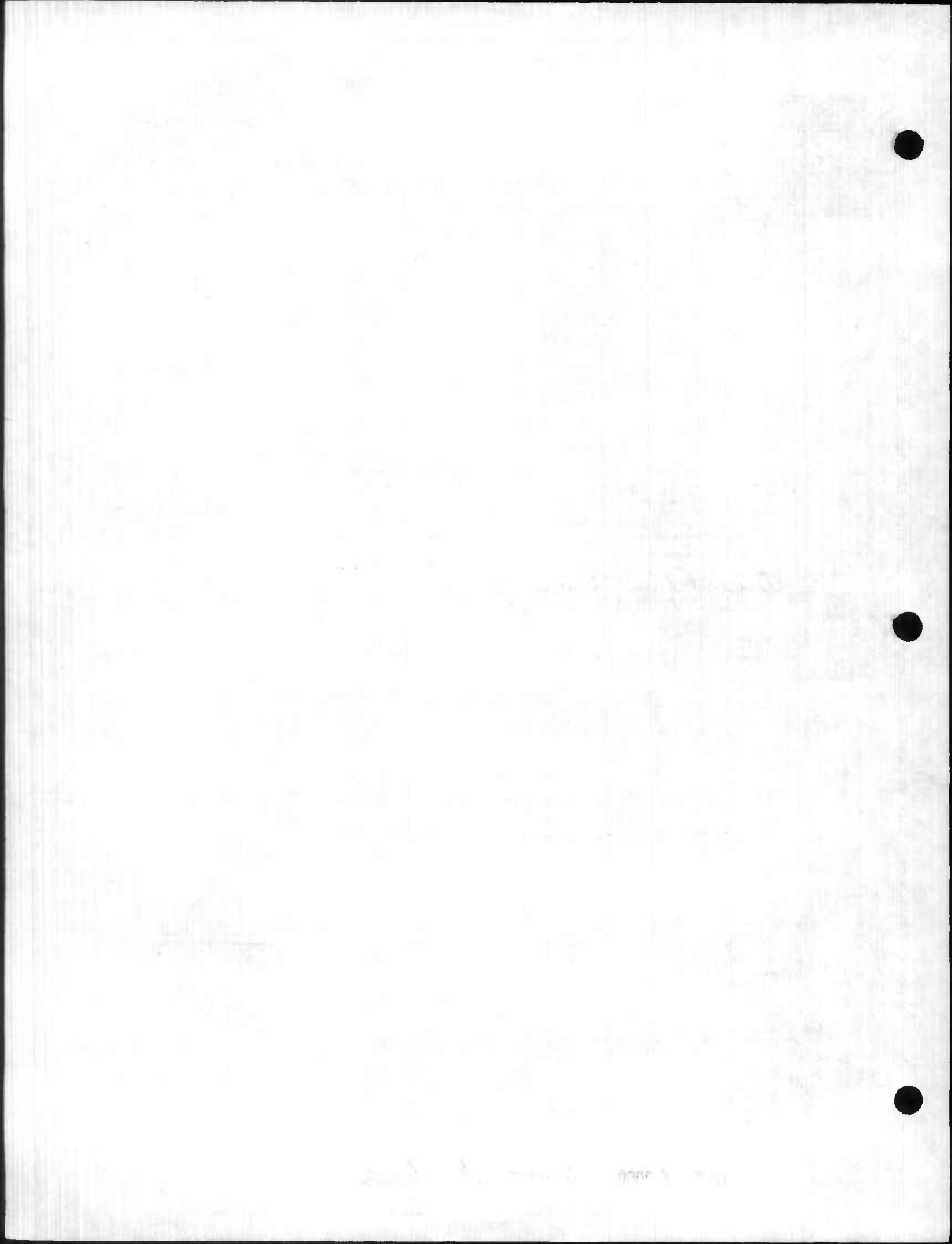
Reg. No.

00 35943

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Doria Breau Lopitz			2. Date of Death Month Day Year October 3, 2000		3. Time of Death 2:47 AM
	4a. Facility Name (If not institution, give street and number) 43097 Fairgrounds Road			4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary's
Funeral Director	5. Social Security Number 005-18-9719	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	8. Date of Birth (Month, Day, Year) January 14, 1921	9. Birthplace (State or Foreign Country) Maine
	Usual Residence of Decedent 10a. State Maryland 10b. County St. Mary's 10c. City, Town or Location Leonardtown			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 43093 Fairgrounds Road			10f. Zip Code 20650		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Civil Service	
17. Father's Name (First, Middle, Last) Fabian Breau			18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Herbert			
19a. Informant's Name/Relationship (Type, Print) Peter Lopitz (Spouse)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43093 Fairgrounds Road, Leonardtown, Maryland 20650			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 10/4/00	20c. Location - City or Town, State Alexandria, Virginia
21. Signature of Funeral Service Licensee <i>Michael J. Henderson Jr.</i>			22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650			
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			a. <i>Failure to thrive</i> Due to (or as a consequence of): POSSIBLE ASPIRATION PNEUMONIA b. <i>possible aspiration</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):			Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimer's Dementia, advanced</i>			23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <i>Daughter's</i> DAUGHTER'S			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier <i>John J. Fenwick</i>			29c. License number DD1380		29d. Date signed (Month, Day, Year) 10.5.00	
30. Name and Address of person who completed cause of death (Item 23a) (Type, Print) John Fenwick, MD Leonardtown, Maryland 20650						
31. Date filed (Month, Day, Year) OCT 6 2000			32. Registrar's Signature <i>B. Sparks</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35944

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alice M. MacLauchlan

2. Date of Death

Oct. 24, 2000

3. Time of Death

1:35 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Caroline Nursing Home

4b. City, Town, or Location of Death

Denton

4c. County of Death

Caroline

5. Social Security Number

082-18-9962

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 22, 1910

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

112 West End Ave.

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Executive Housekeeper

16b. Kind of Business/Industry

City Government

17. Father's Name (First, Middle, Last)

Nicholas J. Macklin

18. Mother's Name (First, Middle, Maiden Surname)

Alice Daniels

19a. Informant's Name/Relationship (Type, Print)

Robert MacLauchlan/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5426 Cannon Rd., Cambridge, MD 21613

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cambridge Crematory

Data

10-26

20c. Location - City or Town, State

Cambridge, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Curran-Bromwell Funeral Home, P.A.
308 High St., Cambridge, MD 2161323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Dementia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 8 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D 31376

29d. Date signed (Month, Day, Year)

Oct. 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Sides, 920 Market St., Denton, MD 21629

31. Date filed (Month, Day, Year)

OCT 27 2000

32. Registrar's Signature

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten signature or text, possibly "J. H. ..."

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35945

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Galen Wilson Mills

2. Date of Death

Month Day Year

October 27 2000

3. Time of Death

1730

Funeral
Director

4a. Facility Name (If not institution, give street and number)

DORCHESTER GENERAL HOSPITAL

4b. City, Town, or Location of Death

CAMBRIDGE

4c. County of Death

DORCHESTER

5. Social Security Number

220-12-1629

6. Sex

X M 2 F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 21, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 Yes X No

10a. Street and Number

1252 Hudson Rd.

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 X Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 X No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Owner/Boatbuilder

16b. Kind of Business/Industry

Boat Manufacture

17. Father's Name (First, Middle, Last)

Bannie Mills

18. Mother's Name (First, Middle, Maiden Surname)

Edna Moore

19a. Informant's Name/Relationship (Type, Print)

Leona M. Mills/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1252 Hudson Rd., Cambridge, MD 21613

20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Dorchester Mem. Park 11-01

Date

20c. Location - City or Town, State

Cambridge, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Curran-Bromwell Funeral Home, P.A.
308 High St., Cambridge, MD 2161323a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 HOUR

15 YEARS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2 X No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 X No

25. Was case referred to medical
examiner?

1 Yes 2 X No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 X Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 X Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-16609

29d. Date signed (Month, Day, Year)

October 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL A. NOSKEWICZ MD, 503 BLEN ST. CAMBRIDGE MARYLAND 21613

31. Date filed (Month, Day, Year)

OCT 30 2000

32. Registrar's Signature

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35946

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harry James milbourne		2. Date of Death Month Day Year OCT.. 27, 2000		3. Time of Death 0615 AM	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL HOSPITAL MEDICAL CENTER		4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 215-44-6978	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 2-19-47
	9. Birthplace (State or Foreign Country) Maryland					
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State md		10b. County Worcester	
	10c. City, Town or Location Pocomoke City, r		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 426 Linden Ave		10f. Zip Code 21851		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: Blk		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction	
	16b. Kind of Business/Industry Brick masonry		17. Father's Name (First, Middle, Last) Donald H. milbourne		18. Mother's Name (First, Middle, Maiden Surname) Elsie M. Ward	
	19a. Informant's Name/Relationship (Type, Print) Connie milbourne (wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 426 Linden Ave Pocomoke City md 21851			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST James CH.		20c. Location - City or Town, State 11/4/00 Pocomoke City, md	
	21. Signature of Funeral Service Licensee Edgar K. Wharton		22. Name and Address of Facility Wharton Funeral Home 2271 Wharton Rd Accokeek, Va 22301			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
				24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier Theodore M. King		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) OCT. 28, 2000		
30. Name and address of person who completed cause of death (Form 23a) (Type, Print) THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201						
State Registrar	31. Date filed (Month, Day, Year) NOV 02 2000		32. Registrar's Signature B. Sparks			

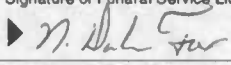
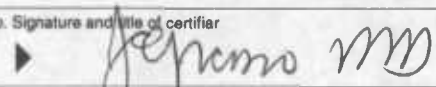
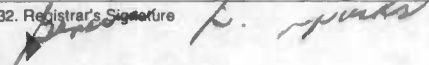
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35947

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROYCE L. MERRITT			2. Date of Death Month October Day 30 Year 2000		3. Time of Death 1154	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER			4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 215-62-0136	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 03 18 53	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
10a. State Virginia		10b. County Accomack		10c. City, Town or Location Bloxom		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 13167 Johnson Circle				10f. Zip Code 23308		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security guard			16b. Kind of Business/Industry Security Industry	
17. Father's Name (First, Middle, Last) James Merritt				18. Mother's Name (First, Middle, Maiden Surname) Betty Lee Poulson			
19a. Informant's Name/Relationship (Type, Print) Kathie Taylor Merritt/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13167 Johnson Circle Bloxom VA 23308			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Downings Cemetery		Date 11-2-00		20c. Location - City or Town, State Oak Hall, VA	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fox Funeral Home P O Box 278-Temperanceville VA 23442			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ventroperic Sepsis (gpn @) Due to (or as a consequence of): b. Squamous Ca Esophagus Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death 12 hr 1 mo
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number D 20507		29d. Date signed (Month, Day, Year) 11/1/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph W. Grasso 145 E. CARROLL ST SALISBURY MD 21804							
31. Date filed (Month, Day, Year) NOV 01 2000		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35948

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Milton Mcintosh</u>				2. Date of Death Month <u>10</u> Day <u>29</u> Year <u>2000</u>		3. Time of Death <u>0315</u> EST	
	4a. Facility Name (If not institution, give street and number) <u>PENINSULA REGIONAL MEDICAL CENTER</u>				4b. City, Town, or Location of Death <u>SALISBURY</u>		4c. County of Death <u>WICOMICO</u>	
Funeral Director	5. Social Security Number <u>220-12-0932</u>		6. Sex <u>1</u> M <u>2</u> F		7. Age (In yrs. last birthday) <u>84</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>12-17-15</u>	
	9. Birthplace (State or Foreign Country) <u>N.C.</u>		10a. State <u>MD</u>		10b. County <u>Worcester</u>		10c. City, Town or Location <u>Pocomoke</u>	
To Be Completed by Funeral Director	10d. Inside City Limits <u>1</u> Yes <u>2</u> No		10e. Street and Number <u>712 9th Street</u>		10f. Zip Code <u>21851</u>		10g. Citizen of What Country? <u>U.S.A.</u>	
	11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8th grade</u> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>production worker</u>		16b. Kind of Business/Industry <u>Poultry</u>		17. Father's Name (First, Middle, Last) <u>Jesse Mcintosh</u>	
	18. Mother's Name (First, Middle, Maiden Surname) <u>Carrie</u>		19a. Informant's Name/Relationship (Type, Print) <u>Elwora Wise (goddaughter)</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>712 9th Street Pocomoke City, md. 21851</u>		20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Mt. Sinai Cemetery</u>		20c. Location City or Town, State <u>11-3-00 Pocomoke md.</u>		21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>Bennie Smith Funeral Home</u> <u>P.O. Box 331 Pocomoke City, md. 21851</u>	
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>ASPIRATION PNEUMONITIS</u> Due to (or as a consequence of): <u>METASTATIC CANCER OF THE PROSTATE</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <u>ASPIRATION PNEUMONITIS</u> Due to (or as a consequence of): <u>METASTATIC CANCER OF THE PROSTATE</u> Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown		24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No		24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No		26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)		27. Manner of Death <u>1</u> Natural <u>5</u> Pending Investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide		28a. Date of Injury (Month, Day, Year)	
	28b. Time of Injury <u>M</u>		28c. Injury at Work? <u>1</u> Yes <u>2</u> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>[Signature] and M.D.</u>		29c. License number <u>D50759</u>		29d. Date signed (Month, Day, Year) <u>10/29/00</u>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>CHARLES FOLASHADE, MD 108 PINEBLUFF RD SALISBURY MD</u>		31. Date filed (Month, Day, Year) <u>OCT 31 2000</u>		32. Registrar's Signature <u>[Signature]</u>		33. Registrar's Title <u>Registrar</u>	

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35949

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT WALTER MITCHELL				2. Date of Death Month October Day 27 Year 2000		3. Time of Death 1435	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 214-28-8150		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) 3/24/1930	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Worcester		10c. City, Town or Location Berlin	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 10156 Hayes Landing RD		10f. Zip Code 21811		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman		16b. Kind of Business/Industry Insurance Co.				
17. Father's Name (First, Middle, Last) Russell Mitchell				18. Mother's Name (First, Middle, Maiden Surname) Emma Smallwood				
19a. Informant's Name/Relationship (Type, Print) Mark E. Mitchell/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10158 Hayes Landing RD Berlin, MD 21811				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Cemetery		20c. Date 10/30/00		20d. Location - City or Town, State Berlin, MD		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD 21811						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Liver failure. Due to (or as a consequence of): b. Rheumatoid Arthritis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Renal failure.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and Title of certifier  mb		29c. License number D 54127		29d. Date signed (Month, Day, Year) 10/27/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alen DAVIS MD 3 Bistek Blvd Delmen MD 21875								
31. Date filed (Month, Day, Year) OCT 30 2000		32. Registrar's Signature  B. Sparks						

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35950

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Frank Maurice, Sr.

2. Date of Death

Month
Oct.

Day
24

Year
2000

3. Time of Death

4:45am

4a. Facility Name (If not institution, give street and number)

1118 Revolution St.

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

214-18-2195

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
03/29/1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1118 Revolution St.

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW2

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Police Officer

16b. Kind of Business/Industry

City Government

17. Father's Name (First, Middle, Last)

George H. Maurice

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Shanklin

19a. Informant's Name/Relationship (Type, Print)

Mack Maurice- Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1118 Revolution St., Havre de Grace, MD 21078

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Angel Hill Cemetery

Date

10/27/00 Havre de Grace, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Dubine M. Smith

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.
123 S. Washington St., Havre de Grace, MD 21078

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

042800

29d. Date signed (Month, Day, Year)

10/25/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. BRADDO MD 319 S. Union Ave., NHC, MD, 21078

31. Date filed (Month, Day, Year)

OCT 26 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

5+1 VA.

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35951

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rella Vivian Marrs				2. Date of Death Month Day Year October 18 2000		3. Time of Death 2:50 AM	
	4a. Facility Name (If not institution, give street and number) Mariner Health of Forest Hill				4b. City, Town, or Location of Death Forest Hill		4c. County of Death Harford	
Funeral Director	5. Social Security Number 215-32-3997		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) October 15 1914	
	9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County Harford		10c. City, Town or Location Darlington	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1706 Whiteford Road		10f. Zip Code 21034		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry			
	17. Father's Name (First, Middle, Last) George A. Shafer				18. Mother's Name (First, Middle, Maiden Surname) Venie A. McMillion			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Margaret E. Crigger Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1706 Whiteford Road, Darlington, MD 21034			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Slateville Cemetery		20c. Location - City or Town, State 10/21 Delta PA		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Jeffrey P. Novak				22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cold cerebrovascular accident Due to (or as a consequence of): Dementia Due to (or as a consequence of): Arteriosclerotic Cardiovascular disease Due to (or as a consequence of): Coronary artery disease				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier J. Lee M.D.		29c. License number D-20661	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) 10/18/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Lee M.D. 669 Revolution St. Havre de Grace MD 21078					
	31. Date filed (Month, Day, Year) OCT 23 2000		32. Registrar's Signature B. Jones					

005 8 9 T20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35952

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elmer Charles Mertz				2. Date of Death Month: October Day: 27 Year: 2000		3. Time of Death 4:00am	
	4a. Facility Name (If not institution, give street and number) 5317 Concord Court				4b. City, Town, or Location of Death Mt. Airy		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 215-05-8486		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) April 3 1912	
	9. Birthplace (State or Foreign Country) MD		10a. State Md		10b. County Frederick		10c. City, Town or Location Mt. Airy	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 5317 Concord Court		10f. Zip Code 21771	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 8 College (1-4 or 5+)	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sheet Metal Worker				16b. Kind of Business/Industry U.S. Coast Guard			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Frederick Mertz				18. Mother's Name (First, Middle, Maiden Surname) Pauline Weiblinger			
	19a. Informant's Name/Relationship (Type, Print) Esther M. Mertz -Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5317 Concord Court Mt. Airy, Md. 21771			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):				20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Park		20c. Location - City or Town, State Sykesville, Md.	
	21. Signature of Funeral Service Licensee Harry W. Haight				22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ALZHEIMER'S DEMENTIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 5 YRS			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION, AORTIC STENOSIS HYPERTENSION, OSTEOARTHRITIS				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how Injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier A. Donelson MD			
To Be Completed by Physician/Medical Examiner	29c. License number J21936				29d. Date signed (Month, Day, Year) 10/27/00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. DONELSON MD 170 TH. JOHNSON DR. SUITE 100 FREDERICK 21702				MARYLAND			
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) OCT 30 2000				32. Registrar's Signature A. Donelson			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

August 1954

August 1954

August 1954

August 1954

August 1954

August 1954

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35953

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Maye Martz				2. Date of Death Month Day Year October 24, 2000				3. Time of Death 9:00am			
	4a. Facility Name (If not institution, give street and number) Fairhaven Health Care Center				4b. City, Town, or Location of Death Sykesville				4c. County of Death Carroll			
Funeral Director	5. Social Security Number 220-09-9544		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) Oct. 13, 1919		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent										10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10a. State MD		10b. County Carroll		10c. City, Town or Location Sykesville								
10e. Street and Number 7200 Third Avenue				10f. Zip Code 21784				10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Domestic				
17. Father's Name (First, Middle, Last) Willard Filmore Wilson				18. Mother's Name (First, Middle, Maiden Surname) Elva Maye Myerly								
19a. Informant's Name/Relationship (Type, Print) Mr. Kermit Martz (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2121 Reifsnider Road Keymar, MD 21757								
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Mem. Park				Date 10/27/00		20c. Location - City or Town, State Sykesville, MD		
21. Signature of Funeral Service Licensee Brian A. Haight				22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death		
a. Chronic obstructive pulmonary disease Due to (or as a consequence of):										years		
b. Pulmonary fibrosis Due to (or as a consequence of):										years		
c. _____ Due to (or as a consequence of):												
d. _____ Due to (or as a consequence of):												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier Ellis Mez MD				29c. License number D22220				29d. Date signed (Month, Day, Year) October 24, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ellis Mez MD 1645 Liberty Rd. Eldersburg, MD 21754												
31. Date filed (Month, Day, Year) OCT 30 2000				32. Registrar's Signature Sparks								

Amended # 8 7d28
10/27/00, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35954

LESTER MUNSON 214-28-6405

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 200-555-5000.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lester Munson		2. Date of Death Month Day Year 10 25 2000		3. Time of Death 3:35 am	
	4a. Facility Name (If not institution, give street and number) Memorial Hospital & Medical Center		4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 214-28-6405	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Year) Aug. 19, 1928
	9. Birthplace (State or Foreign Country) Maryland					
Usual Residence of Decedent						
10a. State Maryland		10b. County Allegany		10c. City, Town or Location Nikep		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number 17733 Pekin Street			10f. Zip Code 21546		10g. Citizen of What Country? USA	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Labor Pipefitter		16b. Kind of Business/Industry Chessie System		
17. Father's Name (First, Middle, Last) Lester Munson			18. Mother's Name (First, Middle, Maiden Surname) Bessie Kiddy			
19a. Informant's Name/Relationship (Type, Print) Anna Riley-Sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17739 Pekin St., Nikep, Md. 21546			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Laurel Hill Cemetery		Date Oct. 28, 2000	20c. Location - City or Town, State Moscow Mills, Md.	
21. Signature of Funeral Service Licensee J. E. McKenzie			22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. Lonaconing, Md. 21539			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARCINOMA OF LUNG Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 7/99.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier [Signature]		29c. License number D0023371		29d. Date signed (Month, Day, Year) OCTOBER 26 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR QAMAR ZAMAN JOHNSON HGTS MEDICAL BLDG 625 KENT AVE SUITE 102 CUMBERLAND, MD 21502						
31. Date filed (Month, Day, Year) OCT 27 2000		32. Registrar's Signature [Signature]				

46

1000 1000 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35955

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gertrude S. McEachern

2. Date of Death

November 6 2000

3. Time of Death

11PM

4a. Facility Name (If not institution, give street and number)

6067 Camelback Lane

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

579 34 9420

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 18, 1927

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6067 Camelback Lane

10f. Zip Code

21045

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Burton Samuels

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Seals

19a. Informant's Name/Relationship (Type, Print)

Chester E. McEachern/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6067 Camelback Lane Columbia, MD 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arbutus Memorial Park 11-11-2000 Arbutus, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

M01044
Sam A. Collins - atty

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.
4112 Old Columbia Pike Ellicott City, MD 2104323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Amyloidosis with liver, heart + kidney involvement 3 months

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Nicholas W. Reuter

29c. License number

D38509

29d. Date signed (Month, Day, Year)

Nov 7, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nicholas W. Reuter 11065 Little Potomac Pk, Columbia MD 21044

31. Date filed (Month, Day, Year)

NOV 08 2000

32. Registrar's Signature

Sandra S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35956

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alwyn LeRoy Nickerson, Sr.				2. Date of Death Month Day Year October 18, 2000				3. Time of Death 12:33 a.m.			
	4e. Facility Name (If not institution, give street and number) Chestertown Nursing Rehab. Center				4b. City, Town, or Location of Death Chestertown				4c. County of Death Kent			
Funeral Director	5. Social Security Number 218-12-1543		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) October 8, 1919		9. Birthplace (State or Foreign Country) Kennedyville, MD			
	Usual Residence of Decedent				10e. State Maryland				10b. County Kent			
To Be Completed by Funeral Director	10c. City, Town or Location Chestertown				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	10e. Street and Number 415 Morgnec Road				10f. Zip Code 21620				10g. Citizen of What Country? USA			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer				16b. Kind of Business/Industry Agriculture			
	17. Father's Name (First, Middle, Last) Augustus LeRoy Nickerson				18. Mother's Name (First, Middle, Maiden Surname) Laura Mabel Hague							
	19a. Informant's Name/Relationship (Type, Print) Sue Nickerson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11588 Lynch Road, PO Box 125, Worton, Maryland 21678							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Kennedyville Methodist Cemetery				20c. Location - City or Town, State 10/21/2000 Kennedyville, Maryland			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Cardio pulmonary Arrest</i> Due to (or as a consequence of): b. <i>Hepatomia</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Right Pleural Effusion</i>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				
28a. Date of injury (Month, Day Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>J. P. Annas Jr M.D.</i>				29c. License number D 23889				
29d. Date signed (Month, Day, Year) 10/18/00				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John C. Annas Jr M.D., 223 High Street, Chestertown, MD 21620								
31. Date filed (Month, Day, Year) OCT 19 2000				32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2005 2 1 700

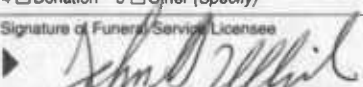

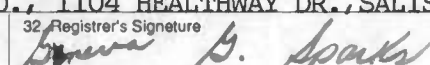
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35957

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SHERRY LYNN PALMER		2. Date of Death Month Day Year OCT. 25, 2000		3. Time of Death 12:10 PM	
	4a. Facility Name (If not institution, give street and number) Salisbury Center Genesis ElderCare		4b. City, Town, or Location of Death Salisbury, Md.		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 215-46-8057	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1-27-47
	9. Birthplace (State or Foreign Country) MD.					
Usual Residence of Decedent						
10a. State MD.		10b. County WICOMICO		10c. City, Town or Location DELMAR		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 607 ELIZABETH STREET			10f. Zip Code 21875		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BOOKKEEPER		16b. Kind of Business/Industry COMPUTERS	
17. Father's Name (First, Middle, Last) ARTHUR FLAXCOMB			18. Mother's Name (First, Middle, Maiden Surname) ALICE KRAMER			
19a. Informant's Name/Relationship (Type, Print) JOANN UNGER SISTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 ROYAL OAKS DR. OCEAN PINES, MD., 21811			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS OF THE PINES		20c. Location - City or Town, State 10-28 OCEAN PINES, MD.	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD.			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
	a. Metastatic Breast Cancer. Due to (or as a consequence of): b. Cadomyopathy Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					MD. yes.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier 			29c. License number D-29349		29d. Date signed (Month, Day, Year) 10/25/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM ROBINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD 21804						
31. Date filed (Month, Day, Year) OCT 27 2000		32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend item#1 HCHD 10-26-00 Certificate of Death

brh Reg. No.

00 35958

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY POWELL

MARY BELLE POWELL

2. Date of Death

Month

Day

Year

3. Time of Death

10 24 00 5:20 AM

4a. Facility Name (If not institution, give street and number)

HCR Manor Care

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

236-32-6497

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 17, 1916

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7637 Charlesmont Road

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Delicatessen Clerk

16b. Kind of Business/Industry

Retail Grocery Store

17. Father's Name (First, Middle, Last)

William Henry Keener

18. Mother's Name (First, Middle, Maiden Surname)

Mattie (UNK) Birch

19a. Informant's Name/Relationship (Type, Print)

Barbara C. Keefover/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7637 Charlesmont Road, Baltimore, MD 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gardens

Date

10/26/00

20c. Location - City or Town, State

Bel Air, MD

21. Signature of Funeral Service Licensee

Steph A. Hughes

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, MD 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ARTERIO SCLEROTIC HEART DISEASE

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

CONGESTIVE CARDIAC FAILURE

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STATUS PACE MAKER

PROGRESSIVE DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

H. C. ...

29c. License number

D24100

29d. Date signed (Month, Day, Year)

10-24-2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

M. L. PRABHAKAR M.D 300 ARMORY PLACE BAL. MD

31. Date filed (Month, Day, Year)

OCT 26 2000

32. Registrar's Signature

James B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35959

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VIRGINIA ETTA PADGETT				2. Date of Death Month Day Year OCTOBER 30 2000		3. Time of Death 6:46P.M.	
	4a. Facility Name (If not institution, give street and number) CIVISTA MEDICAL CENTER				4b. City, Town, or Location of Death LA PLATA		4c. County of Death CHARLES	
Funeral Director	5. Social Security Number 579-40-0687	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) NOV. 30, 1908		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County CHARLES		10c. City, Town or Location LA PLATA		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 1 MAGNOLIA DRIVE				10f. Zip Code 20646		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME		
17. Father's Name (First, Middle, Last) JOSEPH JODIE COOPER				18. Mother's Name (First, Middle, Maiden Surname) MARY MAGDELANE LUMPKINS				
19a. Informant's Name/Relationship (Type, Print) EDWARD PADGETT-SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12850 OWENS DRIVE WALDORF, MD. 20602				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY		20c. Location - City or Town, State 11-3-00 SUITLAND, MARYLAND		20d. Date		
21. Signature of Funeral Service Licensee MO0479 <i>Michael D. L...</i>		22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death line. Immediate Cause (Final disease or condition resulting in death) AZOTEMIA Due to (or as a consequence of): 2-3 DAYS Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last DEMENTIA CARDIAC ARRYTHMIA								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA CARDIAC ARRYTHMIA						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28g. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and Title of Certifier <i>[Signature]</i>				29c. License number D-44436		29d. Date signed (Month, Day, Year) OCTOBER 31 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHVINKUMAR J. PATEL MD 6 INDUSTRIAL PARK DRIVE WALDORF MARYLAND 20601								
31. Date filed (Month, Day, Year) OCT 31 2000		32. Registrar's Signature <i>[Signature]</i>						

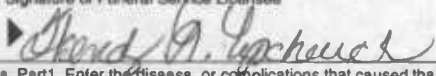
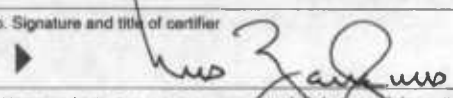
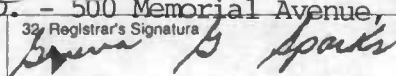
ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 35960

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARTHA ELIZABETH PITTMAN				2. Date of Death Month: OCTOBER Day: 29 Year: 2000		3. Time of Death 7:00 AM	
	4a. Facility Name (If not institution, give street and number) 10 HELMAN DRIVE				4b. City, Town, or Location of Death LAVALE		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 218-16-3487	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) MAY 21, 1921		9. Birthplace (State or Foreign Country) WEST VIRGINIA
	10a. State MD							
To Be Completed by Funeral Director	10c. City, Town or Location LAVALE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 10 HELMAN DRIVE				10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+):		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry HOME			
	17. Father's Name (First, Middle, Last) RAYMOND EDWARD HERSHBERGER				18. Mother's Name (First, Middle, Maiden Surname) FLORENCE OLIVIA UTTERBACK			
19a. Informant's Name/Relationship (Type, Print) C. BONNIE PITTMAN / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 HELMAN DRIVE, LAVALE, MD 21502				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):				20b. Place of Disposition (Name of cemetery, crematory or other place) M.S.V.C.-ROCKY GAP		20c. Location - City or Town, State FLINTSTONE, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PANCREATIC CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 6 months	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Colon Cancer						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number D0054426		29d. Date signed (Month, Day, Year) October 29 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Zang, M.D. - 500 Memorial Avenue, Cumberland, MD 21502								
31. Date filed (Month, Day, Year) OCT 31 2000				32. Registrar's Signature 				

ORIGINAL

44-304

20-10-1944

20-10-1944

20-10-1944

20-10-1944

20-10-1944

20-10-1944

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35961

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CLARENCE EDWARD RUSSELL

2. Date of Death

Oct.

Day Year

31, 2000

3. Time of Death

12:44 PM

Funeral
Director

4e. Facility Name (If not Institution, give street and number)

Salisbury Center; Genesis ElderCare

4b. City, Town, or Location of Death

Salisbury, Md.

4c. County of Death

Wicomico

5. Social Security Number

213-20-4150

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

8/15/1925

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

213 Henry's Mill Dr.

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Medical Representative

16b. Kind of Business/Industry

Drug Co.

17. Father's Name (First, Middle, Last)

Paul Henry Russell

18. Mother's Name (First, Middle, Maiden Surname)

Mary Catherine Barrett

19a. Informant's Name/Relationship (Type, Print)

Mary M. Russell/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

213 Henry's Mill Dr. Berlin, MD 21811

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cape Henlopen Crematory 11/1/00 Frankford, DE

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burbage Funeral Home

108 William St. Berlin, MD 21811

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Complications of Alzheimer's Disease

many years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D-39813

29d. Date signed (Month, Day, Year)

10/31/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD 21804

31. Date filed (Month, Day, Year)

NOV 02 2000

32. Registrar's Signature

Benita B. Sparks

State
Registrar

ORIGINAL

CLARENCE EDWARD RUSSELL
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35962

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Phyllis Elaine Robinson				2. Date of Death Month Day Year Oct. 22 2000		3. Time of Death 2232		
	4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital				4b. City, Town, or Location of Death Havre de Grace		4c. County of Death Harford		
Funeral Director	5. Social Security Number 214-36-9650		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) 12/26/1940		
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State MD		10b. County Harford		10c. City, Town or Location Darlington		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1435 Stafford Road		10f. Zip Code 21034		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home		17. Father's Name (First, Middle, Last) Joseph J. Rompalski		18. Mother's Name (First, Middle, Maiden Surname) Almeda K. Attig	
19a. Informant's Name/Relationship (Type, Print) Lydia Topper- Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Alexander Ct., Owings Mills, MD 21117					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Darlington Cemetery		Date 10/26/00		20c. Location - City or Town, State Darlington, MD			
21. Signature of Funeral Service Licensee Quaine M. Smith		22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BREAST CANCER w METASTASIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - COPD - PNEUMONIA						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? Yes		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 10/26/00		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Quaine M. Smith		29c. License number D42800		29d. Date signed (Month, Day, Year) 10/30/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. Biondo MD, 314 S. Union Ave, H&B, MD, 21078									
31. Date filed (Month, Day, Year) OCT 26 2000		32. Registrar's Signature [Signature]							

ORIGINAL

1001 28 130

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35963

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Rowe		2. Date of Death Month October Day 19 Year 2000		3. Time of Death 17:48
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death
Funeral Director	5. Social Security Number 175-40-5760	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) March 21, 1949		9. Birthplace (State or Foreign Country) Pennsylvania		
Usual Residence of Decedent					
10a. State PA		10b. County Dauphin		10c. City, Town or Location Halifax	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 313 N. Second Street		10f. Zip Code 17032	
10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Real Estate Agent		16b. Kind of Business/Industry Real Estate		17. Father's Name (First, Middle, Last) William Rowe	
18. Mother's Name (First, Middle, Maiden Surname) Anne Grimm		19a. Informant's Name/Relationship (Type, Print) Mrs. Wanda Rowe (wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 N. Second St., Halifax, PA 17032	
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Con-O-Lite Crematory		20c. Location - City or Town, State 10/24/00 Schaefferstown, PA	
21. Signature of Funeral Service Licensee M. T. Z...		22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. multi system organ failure Due to (or as a consequence of):			Approximate Interval Between Onset and Death 5 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Sepsis Due to (or as a consequence of):			7 days
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier G. Brooker D.O.		29c. License number RES-000		29d. Date signed (Month, Day, Year) October 19, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Brooker 600 North Wolfe Street, Baltimore, MD 21207-9106					
31. Date filed (Month, Day, Year) OCT 24 2000		32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

0005 4 8 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35964

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Helen Frances Resker

2. Date of Death
Month Day Year
Oct. 20 2000

3. Time of Death
3:55am

4a. Facility Name (If not Institution, give street and number)

Citizen's Nursing Home

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

012-03-6158

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

8. Date of Birth (Month, Day, Year)

01/23/1912

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

136 Bloomsbury Avenue

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Frank Wozniak

18. Mother's Name (First, Middle, Maiden Surname)

Wladyslawa Wysocki

19a. Informant's Name/Relationship (Type, Print)

Anja Knight- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4401 Colt Lane, Havre de Grace, MD 21078

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Michael Cemetery

Date

10/24/00 Boston, Mass.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Dubine M. Smith

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.
123 S. Washington, Havre de Grace, MD 21078

23a. (Part I) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Stroke

a. Due to (or as a consequence of):

b. Generalized Arteriosclerosis

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Myocardial Infarction
Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Leticia S. Alvarez

29c. License number

D15994

29d. Date signed (Month, Day, Year)

10/20/00

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

LETICIA S. GALVEZ, M.D. 625 S. UNION AVE. HAVRE DE GRACE, MD - 21078

31. Date filed (Month, Day, Year)

OCT 24 2000

32. Registrar's Signature

P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35965

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ETHEL M. RICHARDSON				2. Date of Death Month Day Year Oct. 19, 2000		3. Time of Death 3:10 AM	
	4a. Facility Name (If not Institution, give street and number) Laurelwood Care Center				4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil	
Funeral Director	5. Social Security Number 213-52-0309		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 2/16/1910	9. Birthplace (State or Foreign Country) North Carolina
	Usual Residence of Decedent							
10a. State MD		10b. County Cecil		10c. City, Town or Location Rising Sun			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 338 Chrome Road				10f. Zip Code 21911		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker		16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) Charlie Ashley				18. Mother's Name (First, Middle, Maiden Surname) Lula Roten				
19a. Informant's Name/Relationship (Type, Print) Charles J. Richardson- son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 338 Chrome Rd., Rising Sun, MD 21911				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Union Cemetery		20c. Location - City or Town, State 10/23/2000 Elkton, MD		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Harkins F.H. Inc., 600 Main St., Delta, PA 17314				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. pneumonia Due to (or as a consequence of): b. Alzheimers Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2 wks 5 yrs
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number 044716		29d. Date signed (Month, Day, Year) October 23, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jose Ma 111 W. High St, Elkton MD								
31. Date filed (Month, Day, Year) OCT 24 2000				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

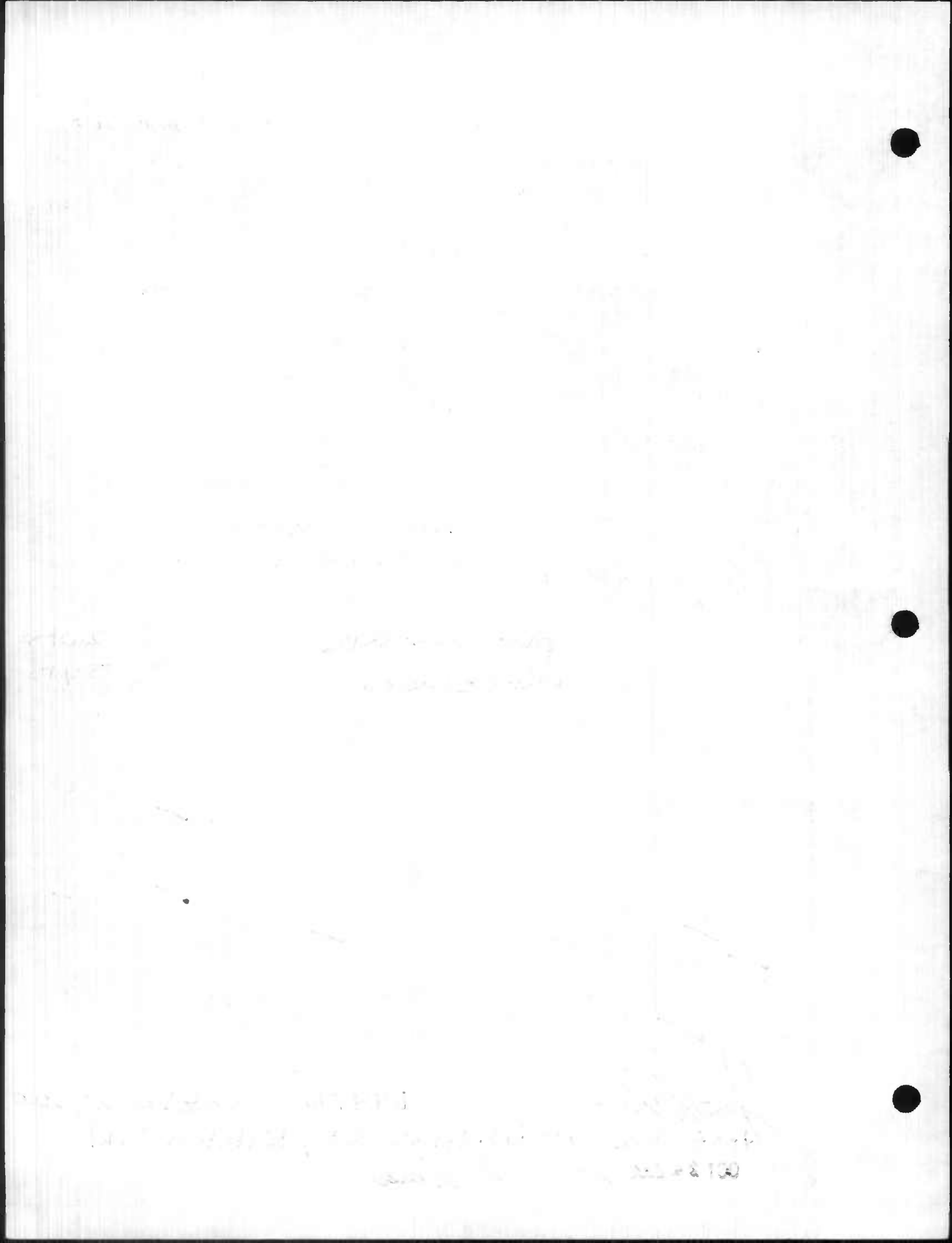
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

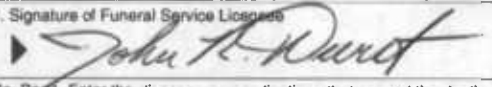
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35966

amend item 5 per fh G791 1/23/01 yf

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Martha Taylor Race				2. Date of Death Month Day Year October 22, 2000				3. Time of Death 04:15 PM	
	4a. Facility Name (If not institution, give street and number) Saint Vincent de Paul Nursing Center				4b. City, Town, or Location of Death Frostburg				4c. County of Death Allegany	
Funeral Director	5. Social Security Number 213-01-5929 216-22-5649		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) 21-Aug-12		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Allegany		10c. City, Town or Location Frostburg				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 40 Beall's Lane				10f. Zip Code 21532-		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) auditor				16b. Kind of Business/Industry hospital			
	17. Father's Name (First, Middle, Last) James A. Taylor				18. Mother's Name (First, Middle, Maiden Surname) Lily Thomas					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Ralph M. Race husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Beall's Lane Frostburg Maryland 21532-					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Frostburg Memorial Park		Date 28-Oct-00		20c. Location - City or Town, State Frostburg, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Alzheimer's Disease Due to (or as a consequence of): years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier 				29c. License number D0054411		29d. Date signed (Month, Day, Year) October 24, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beverly Calkins, M.D., 500 Memorial Avenue, Cumberland, Maryland 21502									
State Registrar	31. Date filed (Month, Day, Year) OCT 24 2000				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

October 25, 2000

October 25, 2000

Mr. [Name]

Mr. [Name]

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35967

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Frank Leslie Robertson

2. Date of Death
Month Day Year
Oct 22, 20003. Time of Death
10:30am

4a. Facility Name (If not institution, give street and number)

73 LaVale Blvd

4b. City, Town, or Location of Death

LaVale

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

214-07-5928

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug 9, 1914

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

FL

10b. County

Broward

10c. City, Town or Location

Laud. By The Sea

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4629 Poinciana Street #511

10f. Zip Code

33308

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Owner/Operator

16b. Kind of Business/Industry

Hair Salon

17. Father's Name (First, Middle, Last)

Ralph Robertson

18. Mother's Name (First, Middle, Maiden Surname)

Laura (Gulbranson)

19a. Informant's Name/Relationship (Type, Print)

Toni Rollins

niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6025 Corkstone Drive; Charlotte, NC 28227

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Scarpelli Funeral Home 2000 Cresaptown, MD

Date

10/22

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home P.A.
Cumberland, Maryland 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Heart Disease

unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) cousins home

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Snow

29c. License number

D09157

29d. Date signed (Month, Day, Year)

Oct 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Snow M.D. 124 W. 3rd Street Cumberland MD 21502

31. Date filed (Month, Day, Year)

OCT 25 2000

32. Registrar's Signature

Paul Snow

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10
msState
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35968

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bertha Earnshaw Russell					2. Date of Death Month Day Year October 29, 2000			3. Time of Death 8:05 AM	
	4a. Facility Name (If not institution, give street and number) Solomons Nursing Center					4b. City, Town, or Location of Death Dowell			4c. County of Death Calvert	
Funeral Director	5. Social Security Number 217-42-2420		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) July 6 1909		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
10a. State MD		10b. County Calvert		10c. City, Town or Location Owings				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 7676 Lake Shore Drive					10f. Zip Code 20736			10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Pinkney A. Earnshaw					18. Mother's Name (First, Middle, Maiden Surname) Bertha Rees					
19a. Informant's Name/Relationship (Type, Print) Ann Theunissen					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7676 Lake Shore Dr. Owings, MD 20736					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) St. John's Church Cem.			Date Oct 31 2000		20c. Location - City or Town, State Clinton, MD		
21. Signature of Funeral Service Licensee Mary J. Goff					22. Name and Address of Facility Lee Funeral Home Calvert, PA 8125 Southern Maryland Blvd. Owings, MD 20736					
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier David J. Tardio MD					29c. License number 097610			29d. Date signed (Month, Day, Year) October 30 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Tardio, MD 120 Hospital Drive Prince Frederick, MD 20678										
31. Date filed (Month, Day, Year) OCT 30 2000			32. Registrar's Signature Benita S. Sparks							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35969

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HOLLIE P. SERPE				2. Date of Death Month Day Year OCTOBER 29, 2000		3. Time of Death 1315
	4a. Facility Name (If not institution, give street and number) 14 CROWS NEST DRIVE				4b. City, Town, or Location of Death OCEAN PINES		4c. County of Death WORCESTER
Funeral Director	5. Social Security Number 342-36-5653	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 7-30-45	9. Birthplace (State or Foreign Country) ILL.
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD.	10b. County WORCESTER	10c. City, Town or Location OCEAN PINES			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 14 CROWS NEST DRIVE			10f. Zip Code 21811		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ADMINISTRATIVE MANAGER		16b. Kind of Business/Industry DIESEL		
	17. Father's Name (First, Middle, Last) GALEN BRILLHART			18. Mother's Name (First, Middle, Maiden Surname) DOROTHY DERRY			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) ANGELO SERPE SPOUSE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 CROWS NEST DR., OCEAN PINES, MD., 21811			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. MARY'S CEMETERY		20c. Location - City or Town, State 11-2 HANOVER TWP., PA.		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD.			
	23a. Part I - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Non Small Cell Carcinoma of Lung Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of Certifier 			29c. License number D30619		29d. Date signed (Month, Day, Year) 10/30/00		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) PETER S ABBOTT MD 10445 Ocean City Blvd Berlin Md 21811							
State Registrar	31. Date filed (Month, Day, Year) OCT 31 2000		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35970

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN E. SINCLAIR			2. Date of Death Month OCTOBER Day 22 Year 2000		3. Time of Death 8:02 P.M.	
	4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL			4b. City, Town, or Location of Death BERLIN		4c. County of Death WORCESTER	
Funeral Director	5. Social Security Number 220-66-5289	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 46 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 7-24-54	9. Birthplace (State or Foreign Country) PA.
	Usual Residence of Decedent						
10a. State MD.		10b. County WORCESTER		10c. City, Town or Location OCEAN CITY		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 705 ST. LOUIS AVE.				10f. Zip Code 21842		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGER		16b. Kind of Business/Industry RESTAURANT		
17. Father's Name (First, Middle, Last) JAMES SINCLAIR				18. Mother's Name (First, Middle, Maiden Surname) DELORES BURKETT			
19a. Informant's Name/Relationship (Type, Print) PATRICIA SINCLAIR				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 ST. LOUIS AVE. OCEAN CITY, MD. 21842			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SUNSET MEMORIAL PARK		Date 10-26		20c. Location - City or Town, State BERLIN, MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD. 21811			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ALCOHOL, COCAINE AND NARCOTIC INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 10/22/00		28b. Time of found? 7:19 P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred unknown		28e. Location (Street and Number or Rural Route Number, City or Town, State) 705 St. Louis Avenue Ocean City, Worcester County, Md.			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) OCTOBER 23, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) OCT 27 2000		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35971

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Vivian Irene Smith

2. Date of Death

October 24 2000

3. Time of Death

9:5A

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

212-32-1122

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 6, 1916

9. Birthplace (State or Foreign Country)

Arkansas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2008 Hanson Road

10f. Zip Code

21040

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Lon (UNK) Tharp

18. Mother's Name (First, Middle, Maiden Surname)

Marie (UNK) Thomas

19a. Informant's Name/Relationship (Type, Print)

Thomas V. Davies/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2008 Hanson Road, Edgewood, MD 21040

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cem.

Date

11/1/00

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

Stephen A. Hughes

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, MD 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. END-STAGE RESPIRATORY FAILURE

years

Due to (or as a consequence of):

b. Atrial Fibrillation with rapid Ventricular Response

Days

Due to (or as a consequence of):

c. Chronic Obstructive Pulmonary Disease

Years

Due to (or as a consequence of):

d. Cachexia

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cor pulmonale, right-sided heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Albert S.C. Sun, M.D.

29c. License number

D 18779

29d. Date signed (Month, Day, Year)

October 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALBERT S.C. SUN, M.D. 1716 Harford Road, Ste 105 Fallston MD 21047

31. Date filed (Month, Day, Year)

OCT 26 2000

32. Registrar's Signature

B. Spence

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35972

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ernest John Stricklin Jr.						2. Date of Death Month Oct Day 22 Year 2000		3. Time of Death 4:30am		
	4a. Facility Name (If not institution, give street and number) 1867 Emily Dr.						4b. City, Town, or Location of Death Edgewood		4c. County of Death Harford		
Funeral Director	5. Social Security Number 213-20-4176		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 25, 1925		9. Birthplace (State or Foreign Country) Md.		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Md.		10b. County Harford		10c. City, Town or Location Edgewood				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 1867 Emily Dr.				10f. Zip Code 21040		10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			16b. Kind of Business/Industry General Motors			
	17. Father's Name (First, Middle, Last) Ernest J. Stricklin Sr.						18. Mother's Name (First, Middle, Maiden Surname) Mamie Belle Kolb				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary M. Stricklin wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1867 Emily Dr. Edgewood Md. 21040				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley		Date Oct 25, 2000		20c. Location - City or Town, State Timonium				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute MI Due to (or as a consequence of): Severe Ischemic Cardio myopathy with Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { c. Retractory CHF Due to (or as a consequence of): HTN CARD. d. Approximate Interval Between Onset and Death 1 Day 3 yrs. 5+ yrs.										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28c. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 						29c. License number D14221		29d. Date signed (Month, Day, Year) 10. 23. 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. A. Brown 227 E. Howard Ave 21221											
State Registrar	31. Date filed (Month, Day, Year) OCT 25 2000				32. Registrar's Signature 						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35973

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT CHARLES SMELTZER				2. Date of Death Month Day Year October 20, 2000		3. Time of Death 10:00 a.m.											
	4a. Facility Name (If not Institution, give street and number) 143 Peppermint Drive				4b. City, Town, or Location of Death Port Deposit		4c. County of Death Cecil											
Funeral Director	5. Social Security Number 214-24-8562		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) 10/10/1926											
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Cecil		10c. City, Town or Location Port Deposit											
Usual Residence of Decedent																		
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																		
10e. Street and Number 143 Peppermint Drive				10f. Zip Code 21904		10g. Citizen of What Country? United States												
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor			16b. Kind of Business/Industry Communications											
17. Father's Name (First, Middle, Last) Frank B. Smeltzer				18. Mother's Name (First, Middle, Maiden Surname) Mollie Myers														
19a. Informant's Name/Relationship (Type, Print) Mrs. Martha C. Smeltzer / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 143 Peppermint Drive Port Deposit, Md. 21904														
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory		Date 10/23/00		20c. Location - City or Town, State Baltimore, Maryland											
21. Signature of Funeral Service Licensee Brian A. Wellen				22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD 21014														
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>metastatic colon cancer</td> <td rowspan="4"> Approximate interval between Onset and Death 3 months 2 years </td> </tr> <tr> <td>b.</td> <td>prostate cancer</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	metastatic colon cancer	Approximate interval between Onset and Death 3 months 2 years	b.	prostate cancer	c.		d.	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	metastatic colon cancer	Approximate interval between Onset and Death 3 months 2 years															
	b.	prostate cancer																
	c.																	
	d.																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown												
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier Jon E. Simon MD			29c. License number DG3156		29d. Date signed (Month, Day, Year) 10-21-00										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3346 Paper Mill Road Phoenix MD 21131																		
31. Date filed (Month, Day, Year) OCT 24 2000			32. Registrar's Signature B. Sports															

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35974

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Alberta Elizabeth Stevenson</i>				2. Date of Death Month <i>October</i> Day <i>18</i> Year <i>2000</i>				3. Time of Death <i>6:20 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Stella Maris Nursing Center</i>				4b. City, Town, or Location of Death <i>Timonium</i>				4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>218-12-4794</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>83</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Feb. 1, 1917</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>	
	Usual Residence of Decedent									
10a. State <i>Maryland</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number <i>3006 Woodring Avenue</i>				10f. Zip Code <i>21234</i>				10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th Grade</i> College (1-4or 5+) <i></i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>				16b. Kind of Business/Industry <i>Own Home</i>		
17. Father's Name (First, Middle, Last) <i>Frank Herold</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Sophie Hvalik</i>						
19a. Informant's Name/Relationship (Type, Print) <i>Lawrence Stevenson (son)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1301 Vermont Road, Bel Air, MD 21014</i>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Most Holy Redeemer Cem.</i>		20c. Date <i>10/23/00</i>		20d. Location - City or Town, State <i>Baltimore, Maryland</i>		
21. Signature of Funeral Service Licensee <i>Mark T. Z...</i>				22. Name and Address of Facility <i>Schimunek Funeral Home, Inc. 9705 Belair Road, Baltimore, MD 21236</i>						
23e. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Upper GI Bleed</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Breast Cancer</i> <i>Dementia</i>										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28e. Location (Street and Number or Rural Route Number, City or Town, State)						
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Christopher Ish</i>				29c. License number <i>053283</i>				29d. Date signed (Month, Day, Year) <i>10/20/00</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dr. Christopher Ish 1147 South Howard St Baltimore MD 21230</i>										
31. Date filed (Month, Day, Year) <i>OCT 24 2000</i>				3. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 00202.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35975

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gloria Jean Souders

2. Date of Death

Month Day Year
October 20, 2000

3. Time of Death

3:10pm

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-44-5015

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 16, 1943

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8634 Saxon Circle

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)
12th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Sales Associate

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Curt Grumbach

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Evans

19a. Informant's Name/Relationship (Type, Print)

Richard Lee Souders (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8634 Saxon Circle, Baltimore, MD 21236

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem.

Date

10/24/00 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Brian A. Wellen

22. Name and Address of Facility

Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

b. Chronic Lymphocytic Leukemia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day
years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Matilda H. So, MD

29c. License number

D26250

29d. Date signed (Month, Day, Year)

10-20-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATILDA H. So, 6701 W. CHARLES ST., BALTIMORE, MD 21204

31. Date filed (Month, Day, Year)

OCT 24 2000

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0036

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

GLORIA SOUDERS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35976

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EVELYN MOHR SAWYER				2. Date of Death Month Day Year OCTOBER 17 2000		3. Time of Death 2:30 A.M.	
	4a. Facility Name (If not institution, give street and number) MARINER HEALTH OF FOREST HILL				4b. City, Town, or Location of Death FOREST HILL		4c. County of Death HARFORD	
Funeral Director	5. Social Security Number 188-07-6131		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) June 19, 1917	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Harford		10c. City, Town or Location Bel Air	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 13 East Ring Factory Road		10f. Zip Code 21014		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home				
17. Father's Name (First, Middle, Last) Milton John Mohr				18. Mother's Name (First, Middle, Maiden Surname) Florence Rosa Jane Durn				
19a. Informant's Name/Relationship (Type, Print) Claire Liskow / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5509 Compadre Ct. NE, Albuquerque, New Mexico 87111				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		20c. Date 10-18-00		20d. Location - City or Town, State Towson, Maryland		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>cerebral vascular accident</u> Due to (or as a consequence of): b. <u>atrial fibrillation</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 2 weeks		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D 3225		29d. Date signed (Month, Day, Year) October 17, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David S. Dunn 65 W. Maple St.								
31. Date filed (Month, Day, Year) OCT 18 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

NOT A SW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35977

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ARNOLD LEROY SCHNAKE

2. Date of Death
Month Day Year
OCTOBER 29 20003. Time of Death
1:25 PM

4a. Facility Name (If not institution, give street and number)

4321 John Street

4b. City, Town, or Location of Death

Suitland

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

579-36-9969

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC 18 1930

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Suitland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

4321 John Street

10f. Zip Code

20746

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Negative Engraver

16b. Kind of Business/Industry

US Government

17. Father's Name (First, Middle, Last)

Walter Leroy Schnake

18. Mother's Name (First, Middle, Maiden Surname)

Zelma Anna Carter Schnake

19a. Informant's Name/Relationship (Type, Print)

MaryLou Schnake (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4321 John Street Suitland, MD 20746

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cem.

Date

11-3-00

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

M00173

22. Name and Address of Facility

Eberwein Funeral Services

4433 White Pls. La. White Pls., MD 20695

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic lung cancer
Due to (or as a consequence of):

Approximate interval between Onset and Death

4 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

D-17605

29d. Date signed (Month, Day, Year)

11/30/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.J. HAIDAK MD

8926 Woodward Road #201 Clinton, MD 20735

31. Date filed (Month, Day, Year)

NOV 01 2000

32. Registrar's Signature

B. Sparta

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35978

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David Jerome Sappington, Jr.				2. Date of Death Month Day Year October 20 2000		3. Time of Death 7:15PM	
	4a. Facility Name (If not institution, give street and number) 2404 Ellsworth Way, Apt 2B				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 218-30-9600		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 21, 1938	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 2404 Ellsworth Way, Apt. 2B		10f. Zip Code 21702	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1961-63	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) supervisor				16b. Kind of Business/Industry aluminum co.			
	17. Father's Name (First, Middle, Last) David J. Sappington, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Evelyn Fletcher			
	19a. Informant's Name/Relationship (Type, Print) Brenda Sappington/ wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2404 Ellsworth Way Apt 2B Frederick, MD 21702			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem. Gardens			
	20c. Location - City or Town, State Frederick, MD				20d. Date 10/25/00			
	21. Signature of Funeral Service Licensee Catharine O. Hartzler				22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MALIGNANT MENINGIOMA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death 8 yrs			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Julio MEMOCAL MD				
29c. License number D-31912				29d. Date signed (Month, Day, Year) 10/23/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julio MEMOCAL MD - 1564 OPOSSUMTOWN PIKE, FREDERICK, MD 21702				31. Date filed (Month, Day, Year) OCT 26 2000				
32. Registrar's Signature Sparks				33. State Registrar OCT 26 2000				

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit data.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35979

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dylan Thomas Stoner						2. Date of Death Month October Day 28 Year 2000		3. Time of Death 01:58			
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore						4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A			
Funeral Director	5. Social Security Number None		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) Yrs. 6		8. Date of Birth (Month, Day, Year) Oct. 22 2000		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Carroll County		10c. City, Town or Location Westminster				10d. Inside City Limits 1 Yes 2 No			
	10e. Street and Number 182 Laurier Drive				10f. Zip Code 21157		10g. Citizen of What Country? United States					
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: white				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) none			16b. Kind of Business/Industry none				
	17. Father's Name (First, Middle, Last) Michael E. Stoner						18. Mother's Name (First, Middle, Maiden Surname) Kathy J. Weant					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Kathy Stoner / mother						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 182 Laurier Drive Westminster, Maryland 21157					
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Lutheran Cemetery		Data Oct 30 2000		20c. Location - City or Town, State Taneytown, Maryland					
	21. Signature of Funeral Service Licensee Alan C. Durin M01072				22. Name and Address of Facility Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Septic shock Due to (or as a consequence of): b. pneumococcal sepsis and meningitis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 13 hours 48 hours	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
							24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
25. Was case referred to medical examiner? 1 Yes 2 No			26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred			
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier Charlotte Glicksman MD						29c. License number D47128		29d. Date signed (Month, Day, Year) 10/28/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charlotte Glicksman, M.D. 2401 W. Belvedere Ave. B-2, Balt. Md. 2145												
31. Date filed (Month, Day, Year) OCT 30 2000			32. Registrar's Signature Beverly B Sparks									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35980

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Maxine Smith

2. Date of Death

Month Day Year
10-18-2000

3. Time of Death

7:55a.m.

4a. Facility Name (If not Institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

213-12-9691

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
May 27, 1921

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

312 Cecilia Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

Church

17. Father's Name (First, Middle, Last)

Robert Granville Smith

18. Mother's Name (First, Middle, Maiden Surname)

Eva M (Lenhart)

19a. Informant's Name/Relationship (Type, Print)

Julie Isner

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

109 Polk Street; Cumberland MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hillcrest Memorial Par 2000

Date
10/21

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.
Cumberland, MD 2150223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Respiratory Arrest

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 days

b. Advanced Anemia

Due to (or as a consequence of):

10 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Extensive Gastrointestinal Bleeding

Due to (or as a consequence of):

20 days

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident, Hypertension, Chronic

Obstructive Pulmonary Disease, Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Shiv C. Khanna

29c. License number

D0054004

29d. Date signed (Month, Day, Year)

October 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khanna, Shiv C., M.D. Johnson Heights Medical Bldg., Cumberland, Maryland 21502

31. Date filed (Month, Day, Year)

OCT 20 2000

32. Registrar's Signature

James B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Division of Vital Records, P.O. Box 68760,

RUTH SMITH 213-12-9691

Amended # 4a, mls,
10/20/00, Allegany Co.

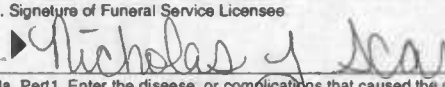


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35981

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES R. STECKMAN				2. Date of Death Month 10 - Day 16 - Year 2000		3. Time of Death 12:56 pm	
	4a. Facility Name (If not institution, give street and number) 710 Memorial Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 215-34-4431		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan 1, 1936	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 525 Eastern Avenue				10f. Zip Code 21502		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates 1954-56		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify white		
15. Decedent's Education (Specify only highest grade completed) 12 Elementary/Secondary (0-12) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) truck driver		16b. Kind of Business/Industry indpdnt trucking		
17. Father's Name (First, Middle, Last) Melvin Steckman				18. Mother's Name (First, Middle, Maiden Surname) Pearl (Crabtree)				
19a. Informant's Name/Relationship (Type, Print) Patricia A. Steckman wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 Eastern Avenue; Cumberland MD 21502				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Rocky Gap Veterans Cem		Date 10/19		20c. Location - City or Town, State Flintstone, MD
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Scarpelli Funeral Home, P.A. Cumberland, MD 21502				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Artery Disease Due to (or as a consequence of): b. Hyperlipidemia Due to (or as a consequence of): c. Diabetes Mellitus Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death 10 Years 20 Years 10 Years								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Mitral Valve Replacement (St Jude) COPD						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of Certifier  George Pellegrino, MD		29c. License number D40095		29d. Date signed (Month, Day, Year) October 18th 2000
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) George Pellegrino, MD 710 Memorial AVE Cumberland MD								
31. Date filed (Month, Day, Year) OCT 20 2000		32. Registrar's Signature 						

Amended # 206, mls
10/23/00, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35982

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eileen Delores Schad				2. Date of Death Month OCTOBER Day 21 Year 2000				3. Time of Death 05:50 AM	
	4a. Facility Name (If not Institution, give street and number) WMHS Sacred Heart				4b. City, Town, or Location of Death Cumberland				4c. County of Death Allegany	
Funeral Director	5. Social Security Number 220 26 9493		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 4-8-1930		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
10a. State PA		10b. County Bedford		10c. City, Town or Location Hyndman				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 113 Clarence Street				10f. Zip Code 15545				10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry Education		
17. Father's Name (First, Middle, Last) William Webster Stahlman				18. Mother's Name (First, Middle, Maiden Surname) Lula Jane Iman						
19a. Informant's Name/Relationship (Type, Print) Ronald G. Schad, spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 374, Hyndman, PA 15545						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Pleasant Ridge Cemetery		Data 10/24/2000		20c. Location - City or Town, State Buffalo Mills, PA				
21. Signature of Funeral Service Licensee Harvey H. Zeigler				22. Name and Address of Facility Harvey H. Zeigler Funeral Home, Hyndman, PA						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Uterine Cancer & metastases to pelvic area							Approximate Interval Between Onset and Death 1 month		
	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pneumonia Anemia leucopenia									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]		29c. License number 1703455		29d. Date signed (Month, Day, Year) OCTOBER 22 2000				
30. Name and address of person who completed causa of death (Item 22a) (Type, Print) R. ESPINA, MD 902 SETON DRIVE, Cumberland MD										
31. Date filed (Month, Day, Year) OCT 23 2000		32. Registrar's Signature [Signature]								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35983

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joan Harriet Shuey						2. Date of Death Month Day Year OCTOBER 19, 2000		3. Time of Death 1630 P.M.		
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital						4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany		
Funeral Director	5. Social Security Number 216-18-1363		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) 29-May-18		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Allegany		10c. City, Town or Location Frostburg				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 92 Braddock Street				10f. Zip Code 21532-				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker				16b. Kind of Business/Industry homemaker			
17. Father's Name (First, Middle, Last) John Smouse						18. Mother's Name (First, Middle, Maiden Surname) Emma Jenkins					
19a. Informant's Name/Relationship (Type, Print) Linda Mackay daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 264 Armstrong Avenue Frostburg Maryland 21532-					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Frostburg Memorial Park				20c. Location - City or Town, State 22-Oct-00 Frostburg, Maryland			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Colon Cancer & metastases Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death 1 yr.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute colitis, dehydration Urinary infection Anemia								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 12/6 [Signature]						29c. License number D03459		29d. Date signed (Month, Day, Year) 20 OCTOBER 2000			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) R. ESPINA, MD 902 SETON DRIVE, CUMBERLAND MD											
31. Date filed (Month, Day, Year) OCT 23 2000				32. Registrar's Signature [Signature]							

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10/10/2008

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10/10/2008

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35984

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harvey Melvin Stouffer

2. Date of Death
Month Day Year
October 23, 20003. Time of Death
12:45 p.m.

4a. Facility Name (If not institution, give street and number)

801 Roeth Ave.

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

214-07-4133

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 16, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

801 Roeth Ave.

10f. Zip Code

21502

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Sales agent

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Edward Stouffer

18. Mother's Name (First, Middle, Maiden Summa)

Pearl (Lybarger)

19a. Informant's Name/Relationship (Type, Print)

Sara E. Stouffer / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

801 Roeth Ave., Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rocky Gap Veterans Cemetery

Date

10/26/2000

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Robert C. Adams

22. Name and Address of Facility

Merritt-Adams Funeral Home, P.A.
404 Decatur St., Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- Dementia

- Parkinsonism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sunil K. Gupta

29c. License number

D0033280

29d. Date signed (Month, Day, Year)

October 23, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunil K. Gupta, M.D., 625 Kent Avenue, Cumberland, MD 21502

State
Registrar

31. Date filed (Month, Day, Year)

001-24-2000

32. Registrar's Signature

Sunil K. Gupta

Harvey Stouffer

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35985

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Sinclair

2. Date of Death

October 26, 2000

3. Time of Death

10:23 AM

4a. Facility Name (If not institution, give street and number)

Saint Vincent de Paul Nursing Center

4b. City, Town, or Location of Death

Frostburg

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

201-14-3529

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

14-Jun-25

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Florida

10b. County

Pinellas

10c. City, Town or Location

South Pasadena

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1411 Durling Drive

10f. Zip Code

33707-

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: *WW II*13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (14 or 5+)
416a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

department supervisor

16b. Kind of Business/Industry

steel manufacturing

17. Father's Name (First, Middle, Last)

James Sinclair

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Smith

19a. Informant's Name/Relationship (Type, Print)

Deloris Johns Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

216 McCulloh Street Frostburg Maryland 21532-

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Monongahela Valley Memorial
Park

Date

28-Oct-00

20c. Location - City or Town, State

Donora, Pennsylvania

21. Signature of Funeral Service Licensee

John R. Durst

22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Physician
/Medical
Examiner23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

*Renal failure*Approximate
Interval Between
Onset and Death*2 wk*

b.

Due to (or as a consequence of):

*Arteriosclerosis**10 yrs*

c.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Hypertension**Septic arthritis**Cardiomyopathy, atrial fibrillation*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

George Breza M.D.

29c. License number

D12532

29d. Date signed (Month, Day, Year)

10/27/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Breza, M.D., 912 Seton Drive, Cumberland, Maryland 21502

State
Registrar

31. Date filed (Month, Day, Year)

OCT 30 2000

32. Registrar's Signature

George Breza

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

023 AM

10-22-68

10-22-68

10-22-68

10-22-68

10-22-68

10-22-68

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10-22-68

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35986

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILDA H. SISLER

2. Date of Death

Month Day Year
Oct. 25 2000

3. Time of Death

8:19 p.m.

4a. Facility Name (If not Institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegheny

Funeral
Director

5. Social Security Number

236-40-9212

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 11, 1925

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

WV

10b. County

Mineral

10c. City, Town or Location

Keyser

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

500 Carskadon Lane, Apt. 404

10f. Zip Code

26726

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jerry McNemar

18. Mother's Name (First, Middle, Maiden Surname)

Ella Rotruck

19a. Informant's Name/Relationship (Type, Print)

Shirley Hott/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 112 New Creek, WV 26743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Knobley Memorial Gardens

Date

Oct. 28

20c. Location - City or Town, State

Martin, WV

21. Signature of Funeral Service Licensee

Brian L. Smith

22. Name and Address of Facility

Smith Funeral Home

85 S. Main Street Keyser, WV 26726

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

3 days

b. Cardiomyopathy

Due to (or as a consequence of):

5 years

c. Coronary Artery Disease

Due to (or as a consequence of):

5 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Chronic Renal Failure

Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Harjit Sidhu

29c. License number

D26907

29d. Date signed (Month, Day, Year)

October 31, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harjit Sidhu, M.D. 925 Bishop Walsh Road Cumberland, MD 21502

31. Date filed (Month, Day, Year)

NOV 02 2000

32. Registrar's Signature

Harjit Sidhu

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5

TMS

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35987

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harold Snitken				2. Date of Death Month Nov. Day 5, Year 2000		3. Time of Death 9:20A.		
	4a. Facility Name (If not institution, give street and number) Hebrew Home of Greater Washington				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 138-07-5551		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		6. Date of Birth (Month, Day, Year) Dec. 22, 1916		
	9. Birthplace (State or Foreign Country) Poland		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Montgomery Village		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 18605 Walkers Choice Rd., #3		10f. Zip Code 20886		10g. Citizen of What Country? United States	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman		16b. Kind of Business/Industry Tobacco Company		17. Father's Name (First, Middle, Last) Soloman Snitken		18. Mother's Name (First, Middle, Maiden Surname) Goldie Sarali	
19a. Informant's Name/Relationship (Type, Print) Sonia Adler (Sister)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Beth Israel Cemetery 11/7/2000		20c. Location - City or Town, State Woodbridge, New Jersey	
21. Signature of Funeral Service Licensee Matthew A. Brown		22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHRONIC RENAL FAILURE Due to (or as a consequence of): b. GENERALIZED ARTERIOSCLEROSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death YEARS YEARS			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR DISEASE GANGRENE OF FOOT		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Steven Lipson MD		29c. License number DO5885		29d. Date signed (Month, Day, Year) 11/05/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN LIPSON 6121 MONTROSE ROAD, ROCKVILLE		31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature Barbara S. Sparks					

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

00 35988

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Paul J. Siani				2. Date of Death Month Day Year NOVEMBER 05, 2000				3. Time of Death 10:02 AM		
	4e. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL				4b. City, Town, or Location of Death COLUMBIA				4c. County of Death HOWARD		
Funeral Director	5. Social Security Number 217 78 8042		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 42 Yrs.		8. Date of Birth (Month, Day, Year) June 29, 1958		9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent										
10e. State MD		10b. County Howard		10c. City, Town or Location Columbia				10d. Inside City Limits 1 Yes 2 No			
10a. Street and Number 5445 Wolf River Lane				10f. Zip Code 21045				10g. Citizen of What Country? United States			
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Installer				16b. Kind of Business/Industry Security Systems			
17. Father's Name (First, Middle, Last) Anthony J. Siani				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Krzywicki							
19a. Informant's Name/Relationship (Type, Print) Anthony J. Siani/Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5445 Wolf River Lane Columbia, MD 21045							
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State 11-9-2000 Catonsville, MD					
21. Signature of Funeral Service Licensee Shirley Collins-Wright				22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Thoracic aortic dissection and rupture Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension										23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
24e. Were an autopsy performed? 1 Yes 2 No										24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Steph A. Radentz, M.D.				29c. License number OCME				29d. Date signed (Month, Day, Year) NOVEMBER 06, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) NOV 08 2000				32. Registrar's Signature Benita B. Sparks							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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AMEND ITEM: #7 PER F.H. G790 12-19-00 WR. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35989

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Wells Sage				2. Date of Death Month Day Year October 13, 2000		3. Time of Death 4:50 p.m.			
	4a. Facility Name (If not institution, give street and number) Heron Point				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent			
Funeral Director	5. Social Security Number 118-01-7671	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87-86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) November 29, 1914		9. Birthplace (State or Foreign Country) New York		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland	10b. County Kent	10c. City, Town or Location Chestertown			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 501 Campus Avenue			10f. Zip Code 21620		10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Physicist			16b. Kind of Business/Industry Research / Anylyst				
	17. Father's Name (First, Middle, Last) Chauncey Snow Sage				18. Mother's Name (First, Middle, Maiden Surname) Amie Leigh					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Lundy Leigh Seymour			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6778 Burris Road, Rock Hall, Maryland 21661						
	20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation Center, LLC		Date 10/14/2000		20c. Location - City or Town, State Stevensville, Maryland			
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home P.A. 130 Speer Road, Chestertown, Maryland 21620						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute coronary vascular accident Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 1 week		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number 7cc13824		29d. Date signed (Month, Day, Year) 10-14-00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John C. Seymour, 122 Speer Road, Suite 5, Chestertown, Maryland 21620										
31. Date filed (Month, Day, Year) OCT 17 2000		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

20

State
Registrar

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AMMEND ITEM#26 PER PHYSICIAN
mp 10/30/2000

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35990

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES EBEL SWANN		2. Date of Death Month October Day 25 Year 2000		3. Time of Death 4:28 PM
	4a. Facility Name (If not institution, give street and number) Civista Medical Center		4b. City, Town, or Location of Death La Plata		4c. County of Death Charles
Funeral Director	5. Social Security Number 577-26-4363	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min
	8. Date of Birth (Month, Day, Year) November 3, 1922		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10a. State MD		10b. County Charles		10c. City, Town or Location Cobb Island	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 12420 Neale Sound Drive			10f. Zip Code 20625		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Quality Inspection Specialist Federal Govt.		16b. Kind of Business/Industry	
17. Father's Name (First, Middle, Last) Joseph Johnson Swann			18. Mother's Name (First, Middle, Maiden Surname) Agnes Johnson Swann		
19a. Informant's Name/Relationship (Type, Print) Sarah A. Swann/Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 46 Cobb Island, MD 20625		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem.		20c. Location - City or Town, State 10/31/00 Cheltenham, MD	
21. Signature of Funeral Service Licensee David C. Ehol		22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. P.O. BOX 567 LA PLATA, MD 20646			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sudden Death - Probable Pulmonary Embolism Due to (or as a consequence of): Chronic Venous Stasis & Insufficiency Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease with Pacer Insertion Spinal Stenosis					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier David Allen M.D.		29c. License number 025230		29d. Date signed (Month, Day, Year) 10/24/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Allen, M.D. 22815 Washington St. Leonardtown, MD 20650					
31. Date filed (Month, Day, Year) OCT 27 2000		32. Registrar's Signature B. Aponte			

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Handwritten text, possibly a date or a short paragraph, located in the middle right section of the page.

Handwritten text, possibly a signature or a footer, located at the bottom of the page.

Handwritten text, possibly a date or a reference number, located at the very bottom center of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35991

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HAROLD JAMES TYNDALL, JR.

2. Date of Death

Month Day Year
10 28 2000

3. Time of Death

10:00 AM

4a. Facility Name (If not institution, give street and number)

4417 Paw Paw Creek RD

4b. City, Town, or Location of Death

Snow Hill

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

217-28-3474

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
8/18/1932

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Snow Hill

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4417 Paw Paw Creek RD

10f. Zip Code

21863

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Car Repair

17. Father's Name (First, Middle, Last)

Harold James Tyndall, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Bradford

19a. Informant's Name/Relationship (Type, Print)

Margie Tyndall/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4417 Paw Paw Creek RD Snow Hill, MD 21863

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Spence Baptist Cemetery 10/31/00 Snow Hill, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burbage Funeral Home

208 W. Federal St. Snow Hill, MD 21863

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. HEPATIC CIRRHOSIS
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

3 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HLRPS ZOSTER

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Robert C. LaMar, MD

D-05865

OCT. 30, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert C. LaMar Md 104 N. Bay St. Snow Hill, Md. 21863

31. Date filed (Month, Day, Year)

OCT 30 2000

32. Registrar's Signature

B. Spence

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
202-555-1234.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35992

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Anna Marie Tischtschenko

2. Date of Death

Month
Oct.Day
15Year
2000

3. Time of Death

3:00am

4a. Facility Name (If not institution, give street and number)

450 Congress Ave.

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

213-34-9925

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
09/12/1926

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

604 Mouser Drive

10f. Zip Code

21015

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

Anna Harreiner

19a. Informant's Name/Relationship (Type, Print)

Rosemarie Miller- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

450 Congress Ave., Havre de Grace, MD 21078

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Andrews Orth. Cem. 10/18/00 Dundalk, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Quaine M. Smith

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.

123 S. Washington, Havre de Grace, MD 21078

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of esophagus
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Barrett's esophagus
Due to (or as a consequence of):c. Gastroesophageal reflux
Due to (or as a consequence of):

years.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. Amorelli M.D.

29c. License number

D14544

29d. Date signed (Month, Day, Year)

OCT 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IAN D. SOMERVILLE 400 LEWIS ST HAVRE DEGRACE MD 21078

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

B. A. A. A.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1005 81 120

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35993

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Emerson Francis Tarburton, III				2. Date of Death Month Day Year October 29, 2000		3. Time of Death 9:12AM	
	4a. Facility Name (If not institution, give street and number) 8762 Dove Drive				4b. City, Town, or Location of Death Bel Alton		4c. County of Death Charles	
Funeral Director	5. Social Security Number 212-42-4667		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) May 2, 1943	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Charles		10c. City, Town or Location Bel Alton	
Usual Residence of Decedent								
10a. State Maryland				10b. County Charles		10c. City, Town or Location Bel Alton		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 8762 Dove Drive				10f. Zip Code 20611		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: '62-'64		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sergeant		16b. Kind of Business/Industry Maryland State Police		
17. Father's Name (First, Middle, Last) Emerson Francis Tarburton				18. Mother's Name (First, Middle, Maiden Summa) Ethel Doris Wilkerson				
19a. Informant's Name/Relationship (Type, Print) Irene M. Tarburton / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8762 Dove Drive Bel Alton, Maryland 20611				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery		20c. Location - City or Town, State Cheltenham, Maryland		Date OCTOBER 31, 2000
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd, Charlotte Hall, MD 20622				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pancreatic Cancer with metastasis to lung Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Approximate Interval Between Onset and Death 1 Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						25b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and Title of Certifier 				29c. License number D27348		29d. Date signed (Month, Day, Year) October 30, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard M. Haft, MD., 12070 Old Line Center-Suite 100, Waldorf, MD 20602								
31. Date filed (Month, Day, Year) OCT 31 2000			32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35994

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHESTER McCLULLEN TWIGG						2. Date of Death Month Day Year OCTOBER 22 2000		3. Time of Death 4:02 AM	
	4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL						4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 219-03-8628		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 27 1920		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 213 HUMBIRD STREET				10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Date: 1944-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PRODUCTION			16b. Kind of Business/Industry FIBER PRODUCTION			
17. Father's Name (First, Middle, Last) LEE TWIGG						18. Mother's Name (First, Middle, Maiden Surname) MAMIE PORTER				
19a. Informant's Name/Relationship (Type, Print) GEORGE L. TWIGG SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 UTAH STREET CUMBERLAND MARYLAND 21502						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) CUMBERLAND CREMATORY		Date OCT 23 2000		20c. Location - City or Town, State CUMBERLAND MARYLAND		
21. Signature of Funeral Service Licensee <i>Dale L. Merritt</i>				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. PERITONITIS Due to (or as a consequence of):										4 WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):										
c. Due to (or as a consequence of):										
d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMONIA C A OF THE COLON										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D 0033280		29d. Date signed (Month, Day, Year) OCTOBER 23, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR SUNIL K. GUPTA 625 KENT AVENUE CUMBERLAND MARYLAND 21502										
31. Date filed (Month, Day, Year) OCT 24 2000		32. Registrar's Signature <i>[Signature]</i>								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35995

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARIAN EILEEN TALMAGE

2. Date of Death

Month Day Year
10 20 2000

3. Time of Death

5:30 AM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital & Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

135-14-2139

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 16, 1922

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

WV

10b. County

Mineral

10c. City, Town or Location

Keyser

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

Rt. 1, Box 138 A-1

10f. Zip Code

26726

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Custom
Garment Shop

17. Father's Name (First, Middle, Last)

John Casey

18. Mother's Name (First, Middle, Maiden Surname)

Marie B. Peters

19a. Informant's Name/Relationship (Type, Print)

Marian Eileen Corallo/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 Hamilton Place Pine Brook, New Jersey 07058

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Thomas Cemetery

Date

Oct. 23

2000

20c. Location - City or Town, State

Keyser, WV

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Smith Funeral Home

85 S. Main Street Keyser, WV 26726

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESPIRATORY FAILURE

Due to (or as a consequence of):

30 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ACUTE RIGHT UPPER LOBE PNEUMONIA

Due to (or as a consequence of):

30 DAYS

c. ACUTE EXACERBATION OF CHRONIC OBSTRUCTIVE

Due to (or as a consequence of):

32 DAYS

d. LUNG DISEASE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SQUAMOUS CELL CARCINOMA OF LUNG

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D23334

29d. Date signed (Month, Day, Year)

OCTOBER 21st, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. DINESH SHAH, JOHNSON HEIGHTS MEDICAL BUILDING, 625 KENT AVE, CUMBERLAND, MD

31. Date filed (Month, Day, Year)

OCT 27 2000

32. Registrar's Signature

State
Registrar

ORIGINAL

MARION TALMAGE 135-14-2139
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-0000.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended #206, NLS
10/31/00, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35996

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) JAMES HOWARD TATE				2. Date of Death Month OCTOBER Day 23 Year 2000				3. Time of Death 2245 PM	
4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND				4c. County of Death ALLEGANY	
5. Social Security Number 223-66-2003		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT. 23, 1951		9. Birthplace (State or Foreign Country) GEORGIA	
Usual Residence of Decedent									
10a. State MD	10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 935 PINECREST DRIVE, #B-1				10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: '74-'76		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SENIOR HAZARDS ANALYST			16b. Kind of Business/Industry ALLEGANY BALLISTICS LABORATORY			
17. Father's Name (First, Middle, Last) OWEN F. TATE				18. Mother's Name (First, Middle, Maiden Surname) VIRGINIA McLARIN					
19a. Informant's Name/Relationship (Type, Print) VIRGINIA M. TATE / MOTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1111 MAIN STREET, DANVILLE, VA 24541					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HIGHLAND BURIAL PARK		Date 10/27/2000 11/28/2000		20c. Location - City or Town, State DANVILLE, VA			
21. Signature of Funeral Service Licensee S. Mark Surrp				22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST. CUMBERLAND, MD 21502					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LIVER FAILURE Due to (or as a consequence of): METASTASES TO THE LIVER Due to (or as a consequence of): COLON CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 5 days	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERCALCEMIA						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Christine Lewis MD				29c. License number D54630		29d. Date signed (Month, Day, Year) OCTOBER 24 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTINE P. LEWIS, MD 224 WASHINGTON STREET CUMBERLAND MD 21502									
31. Date filed (Month, Day, Year) OCT 31 2000				32. Registrar's Signature Sparks					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35997

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Christine Thomas

2. Date of Death

Month Day Year
Oct 29 2000

3. Time of Death

5:25 AM

4a. Facility Name (If not institution, give street and number)

Calvert County Nursing Center

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

Funeral
Director

5. Social Security Number

216 22 0242

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 21 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Prince Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

85 Hospital Road

10f. Zip Code

20678

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Proof reader

16b. Kind of Business/Industry

U.S. Census Bureau

17. Father's Name (First, Middle, Last)

Irving B. Traband

18. Mother's Name (First, Middle, Maiden Surname)

Mary Edna Coale

19a. Informant's Name/Relationship (Type, Print)

John D. Morgan - friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4910 Log Cabin Dr. Lakeland Fl 33809

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Olivet UMC Cemetery

Date

Nov 1 2000

20c. Location - City or Town, State

Lusby Maryland

21. Signature of Funeral Service Licensee

B Rausch

22. Name and Address of Facility

Rausch Funeral Home PA

4405 Broomes Is. Rd. Port Republic MD 20676

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Chronic Obstructive Lung Disease

Approximate
Interval Between
Onset and Death

years

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Peter Wisniewski

29c. License number

D 40370

29d. Date signed (Month, Day, Year)

Oct 30 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter Wisniewski, M.D. Prince Frederick, MD 20678

31. Date filed (Month, Day, Year)

NOV 01 2000

32. Registrar's Signature

Benita B Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 35998

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Benjamin Aubrey Tomb, Sr.						2. Date of Death Month Day Year October 3, 2000		3. Time of Death 11:30 p.m.	
	4a. Facility Name (If not institution, give street and number) 174 Lake Pointe Drive				4b. City, Town, or Location of Death McHenry		4c. County of Death Garrett			
Funeral Director	5. Social Security Number 282-07-4284		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 20, 1912		9. Birthplace (State or Foreign Country) Ohio	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State PA		10b. County Chester		10c. City, Town or Location West Chester				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 459 Chambers Lane				10f. Zip Code 19382		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW 2 Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 yrs.				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/operator			16b. Kind of Business/Industry Milk Processing Plant		
	17. Father's Name (First, Middle, Last) Harry Tomb						18. Mother's Name (First, Middle, Maiden Surname) Gertrude Dimmick			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Benjamin A. Tomb, Jr./son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 459 Chambers Lane, West Chester, PA 19382					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Country Side Crem.		20c. Date Oct 4, 2000		20d. Location - City or Town, State Davidsville, PA			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebral Vascular Accident Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Hospice									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 				29c. License number H26154		29d. Date signed (Month, Day, Year) 10/4/00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 69 Wolf Acres Drive Oakland MD 21550 PAUL D. MILLER DO.									
31. Date filed (Month, Day, Year) OCT - 5 2000		32. Registrar's Signature 								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 35999

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KENNETH JUNIOR URICE				2. Date of Death Month 10 Day 23 Year 2000				3. Time of Death 17:22		
	4a. Facility Name (If not institution, give street and number) Memorial Hospital & Medical Center				4b. City, Town, or Location of Death Cumberland				4c. County of Death Allegany		
Funeral Director	5. Social Security Number 234-44-6715		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) July 5, 1931		9. Birthplace (State or Foreign Country) West Virginia		
	Usual Residence of Decedent										
10a. State WV		10b. County Mineral		10c. City, Town or Location Keyser				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 465 Armstrong Street				10f. Zip Code 26726				10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korean Conflict		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/Operator				16b. Kind of Business/Industry Building Supply Store			
17. Father's Name (First, Middle, Last) Orus Urice				18. Mother's Name (First, Middle, Maiden Surname) Edna Hayes							
19a. Informant's Name/Relationship (Type, Print) Delores Urice/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 465 Armstrong Street Keyser, WV 26726							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Potomac Memorial Gardens		Date Oct. 27 2000		20c. Location - City or Town, State Keyser, WV					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 26726							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIOMYOPATHY Due to (or as a consequence of): b. PLEURAL EFFUSION Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE HYPERTENSION, CORONARY ARTERY DISEASE TYPE 2 DIABETES MELLITUS										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D55079				29d. Date signed (Month, Day, Year) 10 25 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. PAULA WADDY 47 VIRGINIA AVENUE CUMBERLAND MARYLAND 21502											
31. Date filed (Month, Day, Year) OCT 31 2000				32. Registrar's Signature 							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 36000

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Thomas J. Vassallo

2. Date of Death
Month Day Year
October 31, 20003. Time of Death
13:25

4a. Facility Name (If not institution, give street and number)

Lions Manor Nursing Home

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

220-10-7845

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sep 19, 1919

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Seton Drive Ext.

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

barber

16b. Kind of Business/Industry

barber shop

17. Father's Name (First, Middle, Last)

Thomas Vassallo

18. Mother's Name (First, Middle, Maiden Surname)

Anna (Rosingana)

19a. Informant's Name/Relationship (Type, Print)

Thomas Vassallo

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

225 Boyd Avenue; Winchester VA 22602

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Scarpelli Funeral Home

Date

11/01

20c. Location - City or Town, State

Cresaptown, MD

21. Signature of Funeral Service Licensee

James Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1/2 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive Pulmonary disease

Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

James Scarpelli

29c. License number

D33280

29d. Date signed (Month, Day, Year)

October 31, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunil K. Gupta, M.D.; 625 Kent Avenue; Cumberland, MD 21502

31. Date filed (Month, Day, Year)

NOV 01 2000

32. Registrar's Signature

Sunil K. Gupta

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State
Registrar

July 11 1900